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ORIGINAL COMMUNICATIONS.

AN ACCOUNT OF FOUR CASES OF PERNICIOUS MALARIAL FEVER.

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MALARIAL fever may endanger life when it occurs in the very old or very young, and in those enfeebled by disease or other causes; but the term *pernicious* should be restricted to instances in which the symptoms are severe and the paroxysms are prolonged, or in which the effect of the poison falls with special and dangerous violence on a particular organ.

The comatose, the algid, and the hemorrhagic are the chief forms of pernicious fever; other and minor forms are the delirious, the choleraic, the eclamptic, the tetanic, the pneumonic, and so on, an almost endless variety of names being bestowed according to the symptoms most prominently developed.

A number of cases of malaria, of different degrees of severity, were admitted to the medical wards of the Episcopal Hospital during my last term of service, and among them were four examples of pernicious fever. These are worthy of record as well for their intrinsic interest as on account of the comparative rarity of this type of fever in our climate.* I will detail the cases in the order in which they were presented, the histories being compiled from the ward-notes of my resident, Dr. Charles M. Seltzer.

Case I.—Peter —, æt. 23, by trade a blacksmith, but for several months employed as a hand on a canal-boat, was brought to the hospital at noon on October 11, 1880. The only information obtainable was that he had complained of irregular chills for a few days before, that he had been unable to work on the day preceding, and that on the morning of the 11th he was found in his bunk in an unconscious condition.

On admission, there was profound coma, the skin and conjunctivæ were slightly yellow, the lips and extremities were blue, the surface felt cool, the power of deglutition was suspended, there was bilious vomiting, a tendency to rigidity and convulsive movements of the limbs, and retention of urine. The

spleen was greatly increased in size. The respiration was rather labored, and the pulse feeble. A specimen of the urine, removed by a catheter, was found to be unaltered in composition. Sinapisms were applied to the nape of the neck and to the extremities, four grains of sulphate of quinia were injected hypodermically, and nutritious and stimulating enemata were administered. During the afternoon there was a trifling reaction, but there was no return of consciousness, and death occurred before midnight.

At the *autopsy* the spleen was found to be almost black in color, and greatly enlarged, approaching very nearly in size the right lobe of the liver. The liver itself and the cortical portion of the brain were bronzed, the veins and sinuses of the latter were engorged with blood, and there was noticeable sub-arachnoid effusion over the convexity of the cerebrum. The other organs of the body were healthy.

After excluding injury to the skull, and the probability of opium- or alcohol-poisoning, the question to be decided was whether this man was suffering from apoplectic coma due to cerebral hemorrhage or embolism, from uræmic coma, or from the comatose form of pernicious malarial fever. His age and occupation, the history of irregular ague paroxysms, the slight jaundice of the skin and conjunctivæ, the cyanosis of the lips and extremities, the coolness of the surface, the bilious vomiting, and, most of all, the enlargement of the spleen, pointed directly to malarial poisoning. At the same time, the absence of paralysis and organic lesion of the heart and blood-vessels opposed the theory of apoplexy suggested by the deep coma and labored breathing, and the unaltered composition of the urine, that of uræmia, suggested by the convulsive movements of the limbs.

The coma in pernicious fever is usually not so profound as it was here, for ordinarily patients can be roused to answer questions in peevish monosyllables, and low murmurs of complaint, indicating, perhaps, severe headache, may often be heard. This difference, though, was one merely of degree, and may be attributed to the well-defined cerebral lesions observed at the post-mortem examination. The dark color of the cortical portion of the brain, and of the liver and spleen, together with the great enlargement of the latter organ, while confirming the diagnosis, indicated that the paludal influence had been active for a

* Of 780 cases of malaria treated in the Episcopal Hospital during the last ten years, my four cases are the only instances of pernicious fever recorded.

much longer time than might be inferred from the notes.

The record of the next patient's illness illustrates a different and in some respects anomalous train of symptoms.

Case II.—Wm. —, a laborer, 24 years old, was brought to the hospital on the morning of November 10, 1880. The police-officer who had him in charge stated that he had found him in a semi-unconscious condition upon a vacant lot near the hospital, lying by a cart in which he had been hauling ashes. Afterwards it was ascertained that for a week or more he had had irregular attacks of chills, fever, and sweating.

When admitted, there was great hebetude, questions having to be repeated several times, and being responded to slowly and only in monosyllables. His face was expressionless, and, together with the hands and feet, cyanosed. The conjunctivæ were yellowish and somewhat injected. The extremities felt cold, though the axillary temperature was 103° F. The skin of the trunk and thighs was thickly covered with small, dusky-red, petechial spots. His hands were tremulous, and there was general hyperæsthesia. His tongue was coated; there was obstinate vomiting of bile-stained mucus; the belly was unaltered in shape, and there was no very decided enlargement of the spleen. The cardiac sounds were feeble, and the pulse counted 124; the respiration was irregular and somewhat labored, and bronchial râles were heard over the posterior portions of both lungs. There was retention of the urine, but this fluid was normal in composition.

The patient was at once put to bed, the lower bowel was emptied by an enema, two grains of sulphate of quinia and fifteen minims of dilute muriatic acid were administered every three hours, with a diet of milk and beef-tea, and eighteen fluidounces of milk-punch (one fluidounce of whisky to two of milk), in divided doses.

The vomiting recurred at intervals throughout the day, and as evening approached there was slight muttering delirium; the temperature at 6 P.M. was 99°, the pulse 140. During the night there was considerable restlessness and delirium.

On the morning of November 11 the temperature was 98°, the pulse 132; in the evening the temperature was 102° and the pulse 120. From this date until November 17 the fever presented a decidedly remittent type; the nervous symptoms continued, although they became less marked day by day; there was also diarrhoea, and a troublesome cough, attended with a free expectoration of mucus, occasionally streaked with blood. The vomiting, on the contrary, stopped, the petechial eruption faded, and there was a gradual improvement in the appetite and strength. At 8 A.M. on the 17th the temperature was 96.5°

and the pulse 76; subsequently the temperature rose to the normal line, and convalescence proceeded uninterruptedly. The amount of quinia and of milk-punch was slowly reduced, and the diet increased.

The patient was discharged on December 13, 1880.

Here the pernicious paroxysm was preceded by an irregular intermittent fever and followed by a fever which was unmistakably remittent in character.

At first sight the symptoms closely resembled those of typhus fever; thus, there was great hebetude, injection of the conjunctivæ, tremulousness, and hyperæsthesia, a petechial eruption, a high temperature, and a feeble, frequent pulse; on account, however, of the obstinate vomiting, the slight jaundice, and the cyanosis and coolness of the extremities, a positive diagnosis was not made. This reservation proved to be fortunate, as the malarial nature of the disease became apparent after the history was obtained and the range of temperature observed for forty-eight hours.

I have never noted petechial spots in any other case of malaria, and can only explain their existence in this one by supposing them to have been an anomalous manifestation of an inclination towards that form of the disease which is termed *hemorrhagic malarial fever*, and which usually manifests itself by hæmaturia, or by bleeding from the mucous membrane of the stomach, intestinal canal, mouth, or nostrils. When reaction began and the blueness of the lips and extremities disappeared, the skin of the hands and arms, as high as the elbows, presented a red coloration. This redness, associated with the petechiæ, brought to mind the "sub-cuticular mottling" of typhus, described by Dr. George Buchanan as "a faint, irregular, dusky-red, fine mottling, as if below the surface of the skin some little distance and seen through a semi-opaque medium." But as there was also some roughness and slight cracking of the epidermis, the condition was referred to the irritation produced by fine particles of the ashes in which he had been working for some time.

Bronchitis, in my experience, is neither a rare nor a dangerous complication of malarial fever. In my cases the bronchial catarrh has always pursued a regular course, and has not been perceptibly influenced by remissions or intermissions in the fever, although one can readily understand the

occurrence of the intermittent bronchitis and pneumonia mentioned by Hertz.*

The next case is an example of the comatose form of pernicious intermittent fever, and resembles Case I., though the result of treatment was different.

Case III.—Wm. —, æt. 29, entered the hospital early on November 25, 1880. He was a weaver by occupation, was temperate in his habits, and had never had any serious illness. For several years he had worked and resided within a short distance of the hospital. For eight days before admission he had been subject to ordinary paroxysms of quotidian intermittent fever, and during the twenty-four hours immediately preceding had suddenly become unconscious.

When admitted, he was in a state of semi-coma, loud questioning producing merely unintelligible muttering and slight knitting of the forehead. His face, lips, and finger-nails were bluish, while the rest of the surface was pale; there was general hyperæsthesia of the skin, evidenced by the contraction of the brow and low moaning which followed even a light pinch; the forearms and hands were rigidly semi-flexed; the thumbs were locked, and there were occasional convulsive movements of the arms; the pupils were equal. His tongue was dry and brown; it was impossible to induce him to swallow; there was infrequent vomiting of a yellowish liquid, and the bowels were loose. The abdomen was retracted; the liver-dulness was normal in extent, but the area of splenic dulness was considerably increased. The heart-sounds were healthy; sonorous and sibilant rhonchi were audible over both lungs; the pulse was 96 and feeble, the respiration 20 per minute, and the axillary temperature 100.5° F. The urine, removed by a catheter, was non-albuminous. The treatment consisted of three hypodermic injections of four grains of sulphate of quinia, given at intervals of six hours, sinapisms to the calves, and enemata of milk, together with whisky, and of beef-tea, alternately every four hours. The evening temperature was 100°, and the pulse 92.

By the next morning—November 26—there was much improvement; consciousness had to a great extent returned; the hyperæsthesia, the rigidity of the arms, and the cyanosis had nearly disappeared; the tongue was moist, deglutition was performed with little difficulty, and the vomiting and diarrhoea had ceased. Temperature, 99.5°; pulse, 92. The hypodermic injections were discontinued, two grains of sulphate of quinia and fifteen minims of dilute muriatic acid being administered by the mouth every three hours; the nutritious enemata were also substituted by a diet of milk and beef-tea, with six fluidounces of whisky in the form of milk-punch.

After this, with the exception of a trifling attack of lumbago, which yielded readily to counter-irritation, convalescence progressed steadily, and the patient was discharged, perfectly recovered, on December 10, 1880.

In the next case, also an instance of *febris comatosa*, the stage of stupor was succeeded by one of violent delirium; in other words, the distinguishing features of two varieties of pernicious fever—the comatose and the delirious—were associated in the same patient.

Case IV.—D. B., æt. 18, a baker, of temperate habits, residing within a few blocks of the hospital, was admitted at 10 A.M. on November 27, 1880. The friend who brought him stated that for several days he had had paroxysms of chills and fever, and that early on the 27th he suddenly became unconscious. When admitted, he was in a condition of stupor. The pupils were equal and rather dilated; the face, hands, and feet were cyanosed; the arms were rigidly semi-flexed; the thumbs drawn down into the palms, and the fingers tightly clinched over them. His tongue was frosted; it was difficult to introduce liquid into the mouth, and impossible to induce him to swallow. The abdomen was natural in shape. The skin, especially of the extremities, felt cool to the hand.

When I first saw him, two hours later, there was less rigidity of the arms, and pressure over the abdomen caused him to frown and groan uneasily. The axillary temperature was 102° F., the pulse 92 and quite strong, and the respiration slow and rather labored. There was some increase in the area of splenic dulness. The heart and lungs were healthy. The urine, removed by a catheter later in the day, was found to be non-albuminous. The treatment comprised sinapisms to the calves, two hypodermic injections of four grains of sulphate of quinia, one at noon and the other at 6 P.M., a simple enema to clear out the rectum, and subsequently enemata of milk and whisky, and of beef-tea.

During the night of the 27th there was some delirium, and on the 28th he became so violent that restraint was necessary. The face became flushed; the rigidity of the arms disappeared. The temperature at both the morning and evening observations was 101°, and the pulse 88. There was still retention of urine. He swallowed a little food, but the quantity was so small that the nutritious enemata were continued at intervals of four hours. Two hypodermic injections of quinia, four grains each, were given.

On the 29th there was considerable improvement, and he swallowed enough milk and beef-tea to warrant the suspension of the nutritious enemata. Upon the next day he was perfectly conscious and rational. He swallowed easily and readily, passed urine

* Ziemssen's Cyclopædia, vol. ii. pp. 612, 613.

freely, and had a normal temperature and pulse. Twelve grains of quinia were given by the mouth during the day, the diet of milk and beef-tea was continued, and, as the pulse was somewhat feeble, he was ordered milk-punch.

After this, convalescence was rapid, and he was discharged on December 6, 1880.

In the first, third, and fourth cases during the stage of stupor there was rigidity and even convulsive movements of the limbs, an association of symptoms indicating a simultaneous affection of the brain and spinal cord, and a tendency to the eclamptic and tetanic forms of the disease. Such an association, as well as that of delirium and coma in the fourth case, shows, too, that with this, as with many other diseases, it is often impossible to draw a distinct dividing-line between the different varieties. In regard to prognosis, the danger of a fatal termination seems to be proportionate to the development of the nervous symptoms, perhaps the most unfavorable features being decided convulsions and tetanic spasms.

The point of greatest importance in treating pernicious malarial fever is to get the patient as quickly as possible under the influence of quinia. This is most readily accomplished by administering the drug hypodermically, since it must often happen, as it did in three of my cases, that patients are unable to swallow, or that the large dose required when giving the medicine by the mouth is rejected soon after being swallowed, and since cinchonism follows more slowly and less certainly the employment of suppositories of quinia. The objection to the hypodermic method is the danger of producing an abscess or an eschar at the position of injection. Such a result, though common when the necessary solution is effected by either sulphuric acid or muriatic acid, occurs infrequently when the quinia is dissolved by the aid of lactic acid, or even when it is simply suspended in glycerin. In the three cases referred to, and in a number of instances of ordinary malarial fever, and in several of typhoid fever recently treated in my wards, a solution prepared according to the following formula was used:

R Quiniæ sulphatis, gr. xx;
Acidi lactici, ℥xx;
Aquæ, ℥lxxx.—M.

Twenty minims of this solution, containing four grains of sulphate of quinia,

were injected at once into the subcutaneous tissue of the arm or thigh. After the injection there was often slight redness, swelling, and tenderness about the puncture, but in not a single instance was an abscess or an eschar produced.

Four grains of sulphate of quinia may be taken as the average hypodermic dose for cases which are sufficiently severe to demand this mode of administration. This quantity is equivalent to three or four times as much by the mouth. The injection may be repeated once, twice, or three times in twenty-four hours, according to the urgency of the symptoms.

If the pernicious paroxysm is prolonged and the power of deglutition is lost, the strength must be maintained by nutritious enemata. Under these circumstances, the rectum should first be thoroughly emptied by a large simple enema, and then, at intervals of four hours, from four to eight fluidounces of milk and four fluidounces of beef-tea may be injected alternately. This gives twelve or twenty-four fluidounces of milk and twelve fluidounces of beef-tea per day, and is about as much as the rectum can dispose of. As, however, the quantity of liquid so introduced is small, it is a good plan to inject, three times during the day, half a pint of water. Both the food and water should be warm when injected, and the addition of pepsin and malt to the former probably facilitates its absorption by producing changes analogous to those of digestion. If stimulants are indicated, half a fluidounce or one fluidounce of brandy or whisky may be added to each enema of milk and of water. Any irritability of the rectum may be overcome by the use of tincture of opium, gtt. v or x to each enema, and it will be found that the food is much more readily retained and disposed of if the large simple enema is repeated once daily to clear away any material that may have escaped absorption. The act of injection should be performed slowly, and afterwards a warm flannel cloth should be held to and pressed lightly against the anus for a few moments.

Revulsion by sinapisms applied to the nape of the neck and to the calves is of great service in aiding to bring about reaction in malarial coma.

After the pernicious paroxysm is broken the plan of treatment does not differ from that followed in malarial fevers generally.

SYMPTOMS (REFLEX) IN AND ABOUT THE EYE, DUE TO SOME AFFECTION OF THE UTERUS OR ITS APPENDAGES.

Read before the Philadelphia County Medical Society, March 10, 1881.

BY WILLIAM S. LITTLE, A.M., M.D.,

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THE physician whose practice is confined to the affections of one organ or set of organs of the body occasionally discovers a class of cases apparently claiming attention to that organ alone; yet an investigation reveals no lesion, but only reflex symptoms existing, due to disease in some organ proximal or distal, and treatment should either by himself or a proper authority be applied to the source of trouble, so as to obtain special and general relief.

The restriction of one's practice should be the outgrowth of well-founded study of general medicine and surgery, both theoretically and practically. Desire may make a specialist; necessity should always claim his general capabilities.

The ophthalmologist comes across persons who seek relief from eye-trouble or are referred for treatment of supposed eye-disease, yet no lesion is found; or, if treatment is applied for the disease of the eye to which such symptoms belong, no relief ensues. A variety of diseases of the eye present common symptoms; but in this class of cases, finding another organ at fault, treatment of this not only relieves the eye, but a general improvement results.

Reference is made to cases where only eye-symptoms are present and the inference is natural that the eye is at fault, the patient complaining of nothing else, and no available symptoms being present to make the physician think otherwise.

Students should be taught that the eye is part of the body, presenting anatomical conditions, mechanical action, and tissues found elsewhere in the body; and that proximal and distal organs, when in health, have a sympathetic union with the eye; and, when diseased, have secondary, if not primary, lesions in the eye, or produce sympathetic conditions which point to this organ. Knowledge of the anatomy of the eye, combined with as much common sense as is exhibited in treatment of organs whose anatomy is compelled to be known, would relieve the term of spe-

cialism from ophthalmic practice as far as therapeutics and surgery go, the optico-medical and surgical condition excepted.

The sympathetic symptoms and inflammatory processes occurring in the eye in connection with brain-lesion, kidney-affection, syphilis, and rheumatism, are fully known to you. Not sufficient attention has been called to the presence of symptoms in and about the eye associated with affections of the uterus and its appendages.

Clinical observation reveals the proneness of the eye to exhibit alone, symptoms that refer to disease of another organ or set of organs, these diseases not being suspected or symptoms existing to point to them; while, on the other hand, this organ or set of organs being known to be at fault by prominent symptoms, the eye is free from any connection either by sympathetic symptoms or diseased condition, or, if affected in either way, is less prominently so.

To illustrate: in morbus Brightii, more cases will be referred to the practitioner of medicine by the ophthalmologist, which come to him with eye-trouble, due to changes in nerve and retina, from morbus Brightii, than he will find eye-symptoms in cases known to have kidney-affection and sent to him by the practitioner of medicine for additional evidence to be found in the eye. The same may be said of diabetes. Even syphilis manifests itself in this way, and cases of choked disk due to intracranial causes apply for eye-treatment more frequently than one finds choked disk in connection with known brain-lesion. So also with rheumatism. I desire to add the capability of the eye alone, or parts about it, presenting symptoms associated with diseases affecting the uterus and its appendages.

Here let me state that the normal-tissued, perfect-sighted (emmetropic) eye is more free from disease and more readily cured than the abnormal-tissued, imperfect-sighted (ametropic) eye; and this holds for reflex symptoms as well as when the organ alone is at fault or the two conditions combined; the percentage of emmetropic eyes being so low makes the assertion more worthy of advocacy.

The following cases exhibit the practical bearing of my remarks, though I can give no connection between the two organs but the broad base of reflex action through the sympathetic system.

All these cases presented themselves at the Jefferson Medical College Hospital, and were observed and treated by Prof. J. M. Da Costa, of the medical clinic, Prof. Wallace and Dr. Getchell, of the gynecological clinic, Prof. Wm. Thomson and myself, of the ophthalmic clinic.

I am indebted to Dr. J. W. Barr for the notes stating the gynecological condition and treatment.

Case I.—Miss C., æt. 18. Seen January 24, 1878. Sent by a physician for treatment of eyes; was led into the room, eyes protected from light; severe headache for long time, unable to work on account of inability to use eyes; worse at menstrual period; hysterical at times. Found photophobia, blepharo-spasm, lachrymation affecting both eyes, hyperæsthesia over infra- and supra-orbital region both sides and anterior fontanel, great pain on pressure; in fact, the same was general over the whole body. Hearing was modified: right ear, watch at 2 inches, left ear at 8 inches.

Vision, on account of great irritation from light, was $R. E. V = \frac{20}{C}$,

$$L. E. V = \frac{15}{C}.$$

Field of vision at two feet—

R. E., 8 inches circular;

L. E., 6 " "

From the severity of the symptoms, I was led to think that the nerve and retina were implicated, perhaps with meningitis. The ophthalmoscopic examination was difficult at first visit, but revealed hypermetropia, optic nerve slightly red, but no change in retina. It was considered an eye-case: ordered leeches to the temples, iodide of potassium, and hydrarg. bichlor.

January 27.—Symptoms better; $R. E. V = \frac{20}{LXX}$, $L. E. V = \frac{20}{LXX}$; hyperæsthesia still present.

February 2.— $R. E. V = \frac{20}{XL}$,

$L. E. V = \frac{20}{XL}$; gave strychnia $\frac{1}{10}$ gr. t. d.

February 28.—Slight general improvement.

March 10.—Not so well.

March 12.—Atropia for blepharo-spasm.

March 24.—Blepharo-spasm still present; less photophobia.

April 8.—Continues the same; gave bromide of potassium.

April 24.—Field of vision at two feet—

R. E., $14\frac{1}{2}$ inches circular;

L. E., 10 " "

May 6.— $R. E. V = \frac{20}{XL} + 1.d = \frac{20}{XX}$;

$L. E. V = \frac{20}{XL} + 1.25d = \frac{20}{XX}$.

The idea of nerve- and retina-trouble was given up early in the case, and, though

perfect sight was obtained, all the other symptoms remained.

July 7.—Field of vision still limited; other symptoms about the same; consulted medical department.

July 11.—Sent to gynecological department, —the notes are presented,—with final relief of eye-symptoms and general improvement of health.

I have heard from this patient recently, and she considers herself well.

Case I.—Gynecological notes, with treatment. Seen March, 1879. Headache; dyspeptic; menstruated at 15 years, recurring at intervals of one to three months, always scanty and pale, lasting one day. Hysterical spasms at 17 years of age, continued ever since. Not menstruated for two months; occasionally vomited blood. Leucorrhœa; conical os uteri; intense hyperæsthesia of genitals and over abdomen. Vaginitis. Treatment: application of solution of nitrate of silver twice weekly; warm injections twice daily; also leeches. Internally, iron.

Case II.—Miss M., æt. 18. Seen November 2, 1879. Sent from medical clinic for examination of eye-ground and treatment of eye-trouble, which was very severe, she having been treated for epileptoid attacks, which still continued, with hysterical manifestations in addition. The eye-symptoms and facts about the eye appeared identical with those in Case I., and need no repetition.

$R. E. V = \frac{3}{C}$; $L. E. V = \frac{2}{C}$.

Field of vision at two feet—

R. E., 4 inches by 8 inches;

L. E., $5\frac{1}{2}$ inches by 5 inches.

She remained in hospital for six weeks, receiving the same plan of treatment as Case I. Full vision was obtained, but limitation of field of vision and the other symptoms remained about the same; hysteria and epileptoid attacks are prevalent. She was referred to the gynecological department, who treated the condition found and reported in these notes; eye-symptoms were relieved, and general health improved.

Seen February 9, 1881.—No epileptoid attacks for four months. Gave her correction for her optical defect, having compound hypermetropic astigmatism for both eyes; has no eye-trouble.

Seen March 1, 1881.—One epileptoid attack, lasting a few minutes, since last seen; otherwise well, and is gaining her livelihood.

Case II.—Gynecological notes and treatment. Constant headache; pain over left breast and down spine and in lumbo-sacral and inguinal region. Appetite poor; troubled much with flatulency and indigestion. Constant diarrhœa; painful micturition; eruption (acne) over face and chest. Spasm (epileptoid) frequently. Menses irregular, too frequent, and lasting eight days each period.

Endometritis both cervical and corporeal. Leucorrhœa intense. Conical os uteri.

Treatment: application of Monsel's solution to whole of endometrium twice weekly; warm injections twice daily. Internally, general tonics. The notes do not state, but later Dr. Getchell amputated the os uteri. Case discharged well.

Case III.—Miss —, æt. 32, said to be unmarried, presumed childless. Seen November 14, 1880. Gave history of severe fall on head six years ago; has rheumatism, eruptions on skin, hair coming out for some time. Presented all the symptoms as to the eye and about it as Cases I. and II., only more severe—having existed for the last six weeks. Atropia gave no relief for blepharo-spasm; vision reduced; has hypermetropia, field limited. Gave same treatment for one week. Sent to gynecological clinic; their notes are presented.

January 28, 1881.—Eye-symptoms almost entirely disappeared; convalescing from treatment; left hospital few days after, not seen since till March 3, 1881. General health better; bears light with colored glass well; less sensitiveness over affected parts. With correction for optical defect, $V = \frac{20}{XX}$; without, $\frac{20}{C}$, due to compound hypermetropic astigmatism. The symptoms have disappeared more slowly than in other cases, but were far more marked, as the uterine conditions were found to be also.

Case III.—Gynecological notes and treatment. Menstruated at 12 years; menses always irregular, both as to time and quantity. Always complained of headache, and nervous generally. Appetite variable. Pain in lumbo-sacral region and down thighs. Pain over region of womb. Cervix slightly lacerated, result of labor at 21 years. Perineum lacerated extensively. Endometritis both in body and neck. Operated upon by Dr. Getchell in hospital, January 15, 1881, for laceration of perineum. Result, a good perineum, and all symptoms of disorder gradually disappearing. Is well.

No inflammatory processes existed in the eyes of these patients, though if they had existed the same principle would have held, making the cases more complicated, requiring gynecological and ophthalmic treatment, and no positive relief would have ensued till the uterine disorders were relieved, doing away with the reflex symptoms and enabling the eye-symptoms proper to be handled by themselves. I seek, however, to point out reflex symptoms in and about the eye associated with disease of the uterus or its appendages. The eye-symptoms are not numerous; confined to photophobia, lachrymation, blepharo-spasm, decrease of vision, reduction of field of vision, hyperæsthesia of the infra-

orbital and supra-orbital region, region of seventh nerve on face, especially over the exit of these nerves on the face, great sensitiveness over anterior fontanel on pressure. All had hysterical manifestations, and one epileptoid attack. All these symptoms, separately or conjointly, can occur in diseases of the eye, except hysteria and epilepsy; but in these cases there was no eye-disease, no corneal trouble, no vitreous opacity, no retinitis, no neuritis, the hypermetropia present was not enough to account for all, and its correction gave no benefit except to acuity of vision; atropia did not prevent the blepharo-spasm.

Hypermetropia was present in all the cases, showing that ametropic eyes are more liable to symptoms than emmetropic eyes. Though it could no doubt exist in such eyes, myopic eyes have not been seen by me to present the same symptoms.

The first case was treated for eye-disease with no relief, and I was slow to give up the point; the second case was not benefited by a shorter course of treatment of eye-disease; in the third case I began at the other end of the dilemma, and not only eye-symptoms were relieved, but a more serious difficulty arrested and general relief obtained.

These eyes presented no primary lesion, no secondary disease, only reflex symptoms due to nothing but disease affecting the uterus or its appendages. It might be proper to classify such symptoms under the head of hysteria limited in its manifestations to parts in and about the eye. Such cases are not eye-cases. You may remember such cases in your practice, you may meet them hereafter: exclude eye-disease, and seek for the cause where it belongs.

219 SOUTH SEVENTEENTH STREET.

JABORANDI IN GLAUCOMA.

BY P. D. KEYSER, M.D.,

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OCTOBER 8, 1880, Mr. L., æt. 50, called to consult me in relation to a dimness in his vision that had been coming on for some time.

On examination, I found the lens of the right eye cataractous, and some posterior synechiæ,—which he reports has been so for fifteen years,—while his left eye has remained good all the time up to lately. He had, however, been suffering at times with slight shoots

of pain in the eye and a mist before it, which was thicker at times. He had noticed rain-bows and great rays around the flame of the street-lamps, and, at times, in those in a room, especially if the room was very warm. He felt better in the cold air; in a close warm room he could not see. The past few days the cloudiness before the eyes had become more or less permanent.

The vision of the left eye was $\frac{15}{C}$, that of the right was light and passing objects.

He says that he has always been a little near-sighted, for which concave glasses have been worn.

Tension of the left ball was +2.

The field of vision was somewhat reduced in the inner and upper part.

Ophthalmoscopic Examination.—Media clear; optic disk slightly cupped; central vessels very full, but no pulsating artery.

The symptoms of glaucoma being present, I told him the nature of the trouble, and suggested the necessity of operative influence; but, not liking my suggestions, he left, to return the next day more anxious than before about himself, as his vision was more clouded than ever.

On examination now, the fundus of the eye could not be defined, on account of a brown cloud which appeared to be in front of the pupil. By careful illumination, a deep-brown infiltration could be seen in the centre of the cornea over the pupillary region, while the periphery was clear, through which the bluish-gray iris could be plainly perceived.

The tension of the ball had increased to +3.

I now urged the operation, but under no condition would he as yet consent thereto. I then determined to use eserine, but on a second reflection the idea came to me to try the action of jaborandi in its great power on the sudorific and salivary glands in the effect of elimination, knowing that considerable success had been attained by its use in affections of the vitreous, choroid, and detachment of the retina, and that its alkaloid, pilocarpin, locally, had somewhat the effect of eserine. I ordered him to take a teaspoonful (sixty minims) of the fluid extract at bedtime for three nights in succession, after which to see me.

He returned as I requested, and I found the eye very much improved. The tension was reduced to +1; the cornea was perfectly clear, the brown infiltration having entirely disappeared. The jaborandi had caused very profuse sweating, lasting for two full hours every time it was taken, and the salivary flow was very copious. Vision had increased to $\frac{20}{LXX}$. The dimness had passed away, which was naturally to be expected after the reduction of the increased tension and the disappearance of the brown cloud from the cornea.

I still suggested the operation, but no persuasion could get him to consent thereto, he being then satisfied with the improvement.

This is the second case of a brown infiltration in the cornea in glaucoma that I have seen, both of which were absorbed on the reduction of the tension. The first case I reported in the *Philadelphia Medical and Surgical Reporter*, July 18, 1874. Iridectomy was then performed, and complete absorption did not take place until twenty days after the operation. In the above-mentioned case of Mr. L. he was only three days on the use of the jaborandi.

In looking through the literature upon glaucoma, I do not find any mention of this pigmented infiltration in the cornea. Von Graefe first described a sclerous infiltration and a circumscribed rectangular ribbon-form opacity. Shies-Gemuseus called attention to a uniform cloudiness spreading over the whole of the cornea without any change in the epithelium, as is seen in diffused and interstitial keratitis.

October 19, 1880, I was sent for to see Mrs. E., æt. 55, who was not able to leave her room, having been confined to the house for several weeks from an attack of rheumatism. She had been a sufferer, more or less, for years, from rheumatic gout. She was complaining of great pain in and around the eyes, with considerable inflammation in the left one, when I was sent for.

On examination, I found the tension of both balls increased to +3. In the left eye there was considerable pericorneal injection. The pupils were not dilated more than normal. She remarked that at times she had had great flashing of light and falling stars in the eyes, and sometimes rainbows around the lights, and even sharp shooting pains up in the head from the eyes. These premonitory symptoms of glaucoma, however, did not remain long, passing away and leaving the eyes in their former good condition.

The ophthalmoscopic examination showed the media clear, and that there was no cupping of the optic disks nor pulsating artery. She had never had the same feeling of pain and fulness in the eyes as she then had, which had been continuously for three or four days and nights, preventing sleep.

The success of the jaborandi in the previous case recurring to my mind, it suggested the trial of it again, and a teaspoonful of the fluid extract was given that night. The next day I found that she had had a very profuse sweat, with great flow of saliva, for nearly three hours, after which she slept until seven o'clock in the morning. The pain had all passed away, and the tension was reduced to about +1.

She complained of the taste of the jaborandi so much that the next night a hypodermic injection of one-eighth of a grain of nitrate of pilocarpin in solution was substituted, with the happy effect that the next day

all pain and increased tension of the balls were gone.

December 19, 1880, I was called to see an old gentleman in West Philadelphia, who had been blind for some years, but who was then suffering with great pain in the eyes. I found him blind from absolute glaucoma, both eyes. At times he had had attacks of severe pain, but the intervals had become shorter and the pain more exquisite, and for the past few days it was almost unbearable. To relieve him completely from pain, enucleation was advised, which advice was not accepted at that time: so I ordered him to take the fluid extract of jaborandi that night, and prepare himself for a good sweating and salivation. The next morning I found that he had rested very comfortably after the action of the jaborandi had passed away, and was then much relieved from pain.

It is well known that the premonitory attacks of glaucoma do at times pass away spontaneously, more especially after sleep; also that eserine, the active principle of the physostigma (Calabar) bean, used as a collyrium, has the power of relieving for a time these symptoms. In the first instance, as well as in sleep, the natural relaxation that takes place, with the consequent reduction in the intraocular tension, permitting the proper flow of the stagnated or choked blood from the eye, removes the attacks, while the myotic action of the eserine, contracting the pupil as well as constricting the vascular system of the eye, has the same effect of relieving the tension and diminishing the secretion. Pilocarpin, the active principle of the jaborandi, has the same myotic action on the eye that eserine has, but it does not appear to be strong enough alone in its action to relieve the glaucomatous symptoms as promptly.

Now, if thorough relaxation is one of the necessary things in these cases as well as myosis, the jaborandi internally will naturally be one of the effectual remedies to relieve the tension of the system, and therewith the increased firmness of the eyeball, and thus permit the regular circulation to take place for the time being, thereby removing the symptoms and attacks of glaucoma; but, like eserine, it can only be temporary in its action, and cannot effect a permanent cure. The salts of eserine and pilocarpin are somewhat expensive for the patient, and not always readily to be had at the different druggists', while the fluid extract of jaborandi is now so frequently used that it is to be found at a

reasonable price in almost every apothecary's shop in large and small towns.

It is very remarkable that of the eyes lost from disease (not injury) one per cent. is found to be caused by glaucoma, very many of which, as noticed by ophthalmologists, are permitted to go blind for want of knowledge in the physician consulted, to distinguish the premonitory symptoms of this most important and dangerous disease of the eye,—the old story of neuralgia in the eye and head, with occasional dimness of vision, for months or years past, for which quinine, narcotics, etc., *in quantum infinitum aliter ad nauseam*, have been taken, until, finally, the sight is entirely lost, either gradually passing away or by a stormy attack of inflammation.

It is not to be expected, however, that the general practitioner can be so thoroughly learned in ophthalmology as to be able to diagnose correctly all the different diseases of the eye, and especially to perceive the gravity of a glaucomatous affection. It seems natural that the extreme violence of the circumorbital pain and the hemicrania, with but little if any injection or special outward appearances of inflammation, would direct the attention of the physician to neuralgia. But so much has been written in all the medical journals upon the subject of glaucoma during the past ten to twelve years, describing all the peculiar symptoms, with the dangers attending them, that one would suppose the whole profession would be on the alert to notice and diagnose this disease, as well as ready to avert its consequent blindness, knowing full well that the most brilliant triumph in ophthalmology has been gained in the treatment of this affection of the eye.

It is not in all cases that the premonitory symptoms of neuralgic pain—rainbows and flashes of light, etc.—are present, but with a few there are really no symptoms to attract one's attention except a progressive loss of sight. This naturally would mislead the physician not versed in the use of the ophthalmoscope as well as the regulations of the tension of the eyeball; but by careful examination of the field of vision some light may be thrown upon the case, for in such cases a reduction of the field in the upper and inward part is marked, which progresses until the power of vision is limited to directly outward on

the temporal side, and finally is lost altogether.

Eserine and pilocarpin have been found the most efficient remedies as yet to temporarily relieve the painful symptoms of glaucoma until operative influence—the only reliable means of giving permanent relief—is resorted to; but, as before mentioned, these are too expensive and too little used to be found in the stock of drugs of a country practitioner as well as in all the drug-stores of our cities, while the fluid extract of *jaborandi* is a remedy of frequent use, and inexpensive; so that in every case where suffering from an attack of circumorbital neuralgia with dimness of vision and increased tension of the eyeballs is found it would be well to try it in full doses, and if on the next day or two there be any reduction in the tension, remission of pain, with somewhat clearer vision, it should be the duty of the physician to have the patient consult an ophthalmologist at once for careful examination and treatment, if the sight is to be saved.

1630 ARCH STREET.

NOTES OF HOSPITAL PRACTICE.

UNIVERSITY HOSPITAL.

CLINIC OF DR. LOUIS A. DUHRING, PROFESSOR OF DISEASES OF THE SKIN.

Reported by HENRY WILE.

ACUTE VESICULAR AND PUSTULAR DERMATITIS.

CASE I.—The patient before us is a woman about 30 years of age, and exhibits, as you see, an acute inflammation of the skin. The disease seems to be confined to the left forearm, and is of a marked type, being characterized by pustules and vesico-pustules, varying in size from a pin-head to a split pea, scattered over the surface, the whole forming a diffuse patch over the flexor and extensor surfaces of the forearm. Some of the pustules have run together, forming flat pustular areas; others have ruptured, and have formed crusts. You will notice that there is marked oedema of the forearm, and, coming down upon the backs of the fingers we see altogether about a half-dozen disseminated pustules.

On questioning the patient, we find that the disease is of one year's duration,—that is, the patient has undergone five

distinct attacks, this being the fifth. She has had two attacks on the face, one on the right forearm, and one on the left forearm, where the disease is at present located. The patient states that the disease in each attack had always undergone the same development, being characterized by both general and local symptoms. After a high fever the disease manifests itself locally, first by itching, then by pain and a sense of burning, and, finally, by the appearance of red spots, vesicles, pustules, and blebs. The first symptom of the present attack appeared last Saturday (six days ago); thus it has taken nearly a week for the disease to develop into its present condition.

It is very important to get the history of this disease, for without it a positive diagnosis would be difficult, because there are several skin affections which resemble it in external appearances but differ in history and mode of development. The disease, of course, closely resembles eczema, but differs from it in several particulars.

The diagnosis is that of a vesicular and pustular dermatitis of an obscure nature. The treatment, therefore, may be that of any simple inflammation of the skin. We shall give at first a lotion, which is to be followed by an ointment. The following is advised for the first three days:

R Ext. *grindeliæ robustæ* fld., f3j;

Aque, f3viij.

Sig.—Apply as a lotion three times a day.

After the second or third day we shall order the oxide of zinc ointment to be used.

TINEA FAVOSA.

Case II.—A boy 18 years of age, with tinea favosa, the disease occupying a greater portion of the scalp. He states that he has had it since he was nine years old, and is positive that he contracted the same by "lending his pocket-comb to another little boy who had the same disease on the head." After recognizing the disease, we are able, in most cases, to give the history of its development better than the patient himself.

It begins usually in small areas by the development of small, pin-head-sized, yellow crusts, which form slowly. These crusts are situated around the hair-follicles, and they possess a characteristic sulphur-yellow color; they attain the size of a split pea, are decidedly cup-shaped, and,

when they coalesce, form large patches, which, not being removed, may become several lines thick. By separating the hair of the scalp we notice the peculiar yellow crusts, some confluent, others discrete. During the development of the disease the hair becomes exceedingly dry and brittle. In this case we also note several partly bald patches upon the scalp.

This disease may attack any part of the body, but its favorite seat is the scalp. It is caused by the presence of a vegetable parasite known as *Achorion Schönleini*, which was discovered by Schönlein, of Berlin, in 1839. The crusts are made up almost entirely of parasitic matter, together with epithelial scales; hence they are very different from the crusts of eczema, with which disease *tinea favosa* may be confounded.

The disease is contagious, but it does not thrive equally upon all individuals, which is shown by the fact that physicians continually handling cases rarely, if ever, acquire it. It has a characteristic, peculiar, mousy odor, which often alone enables us to make a positive diagnosis. The disease is very rare in private practice, and seldom, if ever, occurs on stout, healthy individuals. It is a disease almost entirely confined to the lower classes, and is mostly found upon the ill-nourished and upon those whose condition of general health is poor.

It is a known fact that the disease may be readily contracted from the lower animals, especially from cats. The following incident may serve as an illustration. A gentleman, while out walking one evening, picked up a little kitten and carried the creature a few paces to his home. The next morning he noticed some crusts on its head, and, fearing something wrong, he destroyed the cat. Ten days later he came to me with two or three small crusts upon the backs of his fingers, and I recognized the disease to be *tinea favosa*, and, by questioning, gained the above history. I may add, by the way, that it required three months for him to be cured, and I may also state that two servants in his household likewise contracted the disease, also upon the hands, by handling the cat.

The disease is thoroughly curable, yet the prognosis should always be guarded, as some cases get well easily, while in others the disease proves to be very obstinate. Three remedies are necessary,—

extreme cleanliness, depilation, and parasitocides. There are a number of parasitocides, any of which may be used. When the virtues of one seem to give out, another should be substituted. The hair of the scalp should first be cut short, and then *sapo viridis*, with hot water, applied to remove the crusts. The application should be made night and morning until the crusts are removed. In the intervals between the applications *cosmoline* may be rubbed in to aid in softening the crusts.

After the crusts are removed the hairs should be extracted with forceps. After this operation some parasitocidal preparation—which is the remedy to be relied upon—should be well rubbed in. The following lotions are recommended:

R Sodii hyposulphit., 3j;

Aquæ, f3j.

Or,

R Hydrargyri chloridi corros., gr. j;

Aquæ, f3j.

Either of these lotions should be freely used, and allowed to remain on for half an hour.

Chrysophanic acid, in the strength of gr. xv—xxx to 3j, is highly recommended; but it should be used with caution, lest a violent dermatitis be set up, not only of the part treated, but upon the adjoining healthy skin. In a case such as the present, where the disease is of long standing, and extensive, months will be required to effect a cure.

TINEA VERSICOLOR.

We have here, in the case of this young man, another parasitic disease, which is known as *tinea versicolor*. It is typical in form and in distribution. It is caused by the presence and development of a vegetable parasite called *Microsporon Furfur*, which gives evidence of its presence by the formation of pin-head, split-pea, and larger-sized patches, of a faint, dirty-yellowish color. These may be discrete or confluent, often covering large areas. The disease in this case is located on the back of the neck, on the shoulders, even extending down on the arm, and on the chest and back. The patches have a smooth appearance and feeling, but, nevertheless, show slight desquamation. The scales are very fine and mealy, being composed of epithelial cells thoroughly filled with the fungus.

The disease yields completely to treatment. The patient will be directed to take a bath daily, using *sapo viridis* freely, and then to apply a parasiticide to the affected part twice a day. We shall order the same lotion of hyposulphite of sodium as in the case of *tinea favosa*. A few weeks will probably suffice to cure the disease. The treatment should be continued for several weeks after all signs of the lesions have disappeared.

ECZEMA VESICULOSUM OF THE HANDS.

The patient is a young man who has a vesicular eruption on the back of his hands and on his fingers. The diagnosis lies between scabies and *eczema vesiculosum*.

The affection here consists of vesicles, pustules, excoriations, and crusts, with but little itching, and with no disposition to spread. The patient says that he has had the disease for one month. It cannot, therefore, be scabies, for in that time the disease would have increased extensively. The disease is *eczema vesiculosum*. The following ointment will be prescribed:

R Hydrargyri chlor. mitis, 3ss;

Ungt. zinci oxidi benz., 3j.

Sig.—Apply twice daily.

TRANSLATIONS.

VEGETABLE ASTRINGENTS.—In a lecture on this subject before the Hygienic Society, Dr. Lewin, of Berlin (*Deutsche Med. Wochens.*, 1881, p. 202), says that if there is one therapeutic principle which has seemed firmly established it has been the influence of tannic acid and the substances composing it upon the animal tissues. Dead tissues are known to be hardened and toughened under its influence, and living muscle and skin are believed to undergo similar changes. Reasoning from these facts, it has seemed unquestionable that a similar effect is produced on the vascular walls, so that diminished secretion as well as the cessation of parenchymatous bleeding, with contraction of the blood-vessels, is produced by its influence. Recent researches, however, go to contradict this long-cherished theory. By bringing a solution of tannin in contact with the mesentery of the frog, Rosenstein succeeded in developing—not contraction, as might have been expected, but dilatation.

For this reason he is inclined to remove tannin from the class of astringents.

This discovery of Rosenstein's, together with the paucity of facts concerning the action of tannin to be found in the textbooks, and the statement therein given that the influence of tannin is a purely local one, led Lewin to enter anew into the examination of the subject. The conclusions of his researches are given in this lecture, as follows:

Tannin coagulates albumen and albuminous substances. The albuminate of tannin thus formed is soluble in an excess of albumen, in lactic acid, in carbonic acid, and in the caustic alkalies. Tannin loses the peculiarity of causing coagulation if it is made slightly alkaline. Pepsin and peptones in solution are precipitated by tannin, but these precipitates are soluble in the hydrochloric acid of the stomach. Thus it is that, as has already been proved, artificial digestion of albumen goes on in a normal manner under the influence of tannin, that no hindrance is offered to the formation of peptones, and that the pepsin present is not precipitated on account of the hydrochloric acid present. It is of course understood that tannin only precipitates the albumen of the blood when it is in sufficient quantity to give an acid reaction to the fluid: the albuminate of tannin thus formed is dissolved again in an excess of alkaline blood.

The possibility of the absorption of tannin is thus explained. Small quantities of tannin are taken up into the lymphatic circulation with the food, and are sent into the blood-circulation as alkaline tannates. Dr. Lewin has succeeded in showing that the tannin thus absorbed is not all metamorphosed, some remaining and being discharged in the urine as tannin. It thus appears that tannin may reach the various parts of the body still preserving its therapeutic qualities. The urinary secretion is diminished under the influence of tannin, and Lewald has shown by quantitative examination that in Bright's disease the quantity of albumen in the urine markedly decreases under the influence of the drug. The widening of the capillaries of the frog's mesentery under the influence of tannin is explained by the occurrence of stasis in the capillaries. The directly-applied tannic acid solution diffuses into the capillaries, causes coagulation there, and, as a result of this, the vessels lying

beyond the affected capillaries experience dilatation from stasis.

As a practical result of his investigations, Dr. Lewin recommends a new form of administering tannin. Experience shows that tannin solution and, still more, powdered tannin not infrequently fail in the desired effect; secondary influences are exerted, which show themselves in irritation of the gastro-intestinal canal, pressure in the epigastrium, loss of appetite, coated tongue, diarrhoea, etc. These evil effects are obviated if the tannin is given in the form of an albuminate. If to a one to two per cent. solution of tannin a filtered solution of an egg in one hundred centimetres of water is added, and the mixture well shaken, an opalescent, light, milky-colored fluid results which has a much less astringent taste than the corresponding tannic acid solution. It may be prescribed thus:

R Sol. acid. tannic. (2 per cent.), gr. cl;

Add, shaking,

Sol. albumin. ovi un., gr. c.—M.

This solution gives good results even when much diluted, and may be used in very young children.

DIAGNOSIS BETWEEN SENILE GENERAL PARALYSIS AND SENILITY.—The distinction between general paralysis and apparently similar cases of senile feeble-mindedness is not always easy to make, and the diagnosis cannot be based upon the patient's age. True paralysis may occur at an advanced age, while senility may come on long before the individual has neared the end of life. Drs. Seppi and Riva (*Deutsche Med. Wochens.*, 1881, p. 207, from an Italian source) suggest the following points. 1. The most prominent anatomical characteristics of paralysis are aneurism of the cerebral arteries, hypertrophy of the interstitial connective tissue of the brain, fatty and pigmentary infiltration of the ganglion-cells, and finally diffuse atheroma. The chief distinctive clinical peculiarities are atheromatous pulse and slight severity of the apoplectic attacks. Lack of tendency to fever, and the absence of those periodic variations of temperature characteristic of the other form of brain-trouble, as well as the progressive loss of the mental faculties, in connection with vague delirium and invalidism, and without any tendency to the *délire des grandeurs*, are all characteristic.

SCROFULA AND TUBERCULOSIS.—At a recent meeting of the Société des Hôpitaux (*La France Méd.*, 1881, p. 368) Dr. Villemin remarked that formerly the word "scrofula" was employed solely to designate ganglionic tumefactions of the neck, suppurating ganglions, etc. Later, all ganglionic alterations were included under this category, and then superficial changes in the skin and mucous membranes. It may be the case, after a while, that this term may include and serve to designate all those alterations at present termed syphilitic and rachitic, including also "morve" and farcy. Scrofula must, then, be divided—like syphilis—into primitive, secondary, tertiary, quaternary. When it is perceived that we have gone too far, then syphilis and "morve" will be eliminated. M. Villemin cannot admit that tuberculosis and scrofula are one and the same, that tuberculosis is nothing more than a manifestation of scrofula. There are numbers of tuberculous persons who have never presented a sign of scrofula. In fact, the tubercular lesions no more belong to scrofula than do the manifestations of syphilis, which were formerly supposed to be connected with scrofula.

The characteristics of a disease are not more in the lesion than in the cause. The etiological element is the most important. Has not M. Kiener shown that cold abscesses, alterations in the synovials and the bones, are nothing more than tubercular affections? Instead of asserting that patients dying tuberculous were scrofulous previously, why not assert that, being tuberculous, they have succumbed to an extension of the affection? M. Villemin does not believe in the existence of scrofula as a morbid entity. There are only scrofulous affections, and there is scrofulosis, which is only a morbid translation of the lymphatic temperament. He did not know that the subjects of scrofulosis were more apt than other persons to become tuberculous. Scrofulosis, however, may so modify the vital tissues as to render them more apt to become tuberculous. Such is the opinion expressed by M. Bouchardat in his recent lectures. It is therefore erroneous to include many of the manifestations of tuberculosis under the head of scrofula.

OSTEOTOMY FOR RACHITIC CURVATIONS OF THE BONES.—A memoir on this subject by Dr. Boekel, analyzed in *La France*

Médicale (1881, p. 411), gives an account of the method of operation in these cases.

The time of operation depends upon the condition of the patient. It may be carried out when the manual osteoclastic procedure has failed: the latter should in every case be first attempted. The operation should not be performed until the cause which has softened, deformed, and again hardened the bones has been removed. The operation of osteotomy, according to M. Boekel, should be subcutaneous, sub-periosteal, and total; it may be linear or wedge-shaped. It is performed as follows. 1. Incision of the soft parts as small as is possible, and simply sufficient to permit the play of the scissors; this incision should be vertical, and should go straight down to the bone. 2. The periosteum should be stripped with the aid of the handle of the bistoury or by means of a special instrument. 3. The bone should be divided at the point of maximum curvation. The section should be total: if partial, troublesome suppuration or other difficulty is apt to be caused by the necrosis of splinters of bone broken off in straightening. 4. The operation of straightening then follows. 5. Then finally comes the dressing, which should be performed by the antiseptic method without immediate reunion.

The operation almost always results favorably. There is scarcely any reaction. Consolidation takes place, with rare exceptions, within four weeks, and is durable. Of one hundred and eighty-one cases operated upon by M. Boekel, osteo-myelitis has never supervened, nor have any terminated fatally.

ASPIDOSPERMIN—THE ACTIVE PRINCIPLE OF QUEBRACHO.—At a recent meeting of the Greifswald Medical Society (*Deutsche Med. Wochens.*, 1881, p. 208) Dr. Eulenburg read a paper on the active principles of a number of drugs which have recently come into vogue, and among them of the alkaloid aspidospermin extracted from quebracho bark. Gehe & Co., the well-known chemists, have made a citrate. It occurs as a yellowish-gray powder or in rhombic crystals, and, contrary to the statement made in Gehe's circular, is insoluble in water. It is soluble, however, in fifty parts of water to which four or five parts of nitric acid have been added. In cold (absolute) alcohol, ether, and glycerin the preparation is scarcely at all soluble.

Boiling alcohol, however, dissolves one part to ten. The acidified watery solution shows a somewhat reddish color after long standing, but remains clear. Subcutaneous injections of .02-.04 centigramme in the rabbit failed to produce any marked symptoms. In frogs the aspidospermin caused primary respiratory paralysis.

PAPAYOTIN.—In the paper mentioned above, Dr. Eulenburg also spoke of the active principle of the *carica papaya*, a Brazilian fruit used in dyspepsia. Papayotin is extracted from the milky sap and also from the leaves. The preparation of papayotin examined by Eulenburg was insoluble not only in alcohol and ether, but also in hot and cold water and glycerin. Even on the addition of acid but a small proportion of the salt was soluble. Experiments made as to the digestive properties of papayotin were negative in their result. Albumen remained undissolved.

HYPODERMIC ADMINISTRATION OF IRON.—Eulenburg, in the paper above alluded to, spoke also of the hypodermic administration of iron, the most convenient preparation of which for this purpose is, in his opinion, the pyrophosphate, with citrate of sodium,—a preparation to be recommended on account of the large proportion (26.6 per cent.) of iron which it contains. In watery solution 1-5 it may be used without local irritation. Within half an hour the urine shows iron.

EPITHELIOMA OF THE TONGUE FOLLOWED BY SECONDARY DEPOSITS IN THE HEART.—Dr. Ch. Féré (Société Anatomique, *Le Progrès Médical*, 1881, p. 281) reports the case of a man of 64, whose tongue was removed for epithelioma. The disease recurred, and the patient finally died of exhaustion. At the autopsy the organs in general (except, of course, the tongue and neighboring ganglia) were found healthy. In the wall of the left ventricle, however, were three pea-sized nodules of a typical epithelioma.

THYMOL IN RINGWORM.—Mr. Malcom Morris recommends the following:

R Thymol (vel Menthol), 3ss;
Chloroformi, ʒij;
Olei olivæ, ʒvj.—M.

To be painted or gently rubbed on the part.

THE cash income of St. Bartholomew's Hospital for 1880 was three hundred and eighty-five thousand dollars.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, JUNE 18, 1881.

EDITORIAL.

PASSING ON THE OTHER SIDE
OF THE WAY.

THE trial and acquittal of Lizzie Aaronson for infanticide has recently drawn attention very forcibly to a weak link in the chain of Philadelphia's charities. Brought to this city and deserted upon the eve of maternity by her seducer, she applied to several institutions for relief, notably to the City Hospital, to the Home Mission, Christian Association, etc. At the Board of Guardians' office she was required to make affidavit as to the name of her supposed husband, and, failing to do this, was refused admission to the Almshouse.

At no other place was relief found, until she was given shelter by a prostitute of the lower class, whose male paramour finally turned her out, when she dragged herself into a low lodging-house, and by pledging a ring secured a room for the night. The next morning, in the court below, the dead child was found by the police. Skilfully directed expert testimony, aided by sympathy on the part of lawyers and judges, succeeded in picking flaws and securing a verdict of acquittal, which in turn was followed by a shower of newspaper articles, mostly censuring the Guardians of the Poor and hospital authorities for their want of the common feelings of humanity. Very few, if any, editors seem to recognize the fact that a hospital must be managed upon business principles,—that it cannot afford relief beyond the means at its command, and that the cases must be rightly selected for admission. To put a lying-in woman in a general hos-

pital is, of course, to expose her to a great risk of death, and is unjustifiable.

That there is at present excessive difficulty in getting patients into the city hospital we know from experience, and in the instance of Lizzie Aaronson the rules seem to have been applied with brutal indifference,—an indifference which we fear is shared by many persons in our midst whose position in society is far above that of the Almshouse officials.

It will, however, be well worth the sacrifice of one foundling if general attention is called to the whole subject. The abhorrence of unchastity is of course very commendable, but the peculiar development of it witnessed in this City of Brotherly Love is not so savory. After a good deal of experience, we have failed to find one fashionable saloon or even one religious parlor whose doors are shut against any young man of ability and social position because he is unchaste, even though his amours are not hidden; and every one who knows anything about the matter knows that men who have been notoriously loose in this respect continually contract brilliant marriages. Yet when a poor, deserted woman, whose sin perhaps has been almost forced upon her by circumstances, comes to the hour of her travail, she must needs lie in the streets, or, if she be fortunate, be taken into the city hospital, to be herded with those who are hopelessly deep in the mire of impurity, and to have all opportunity of rescue denied her. Most of our readers have heard of the Preston Retreat, an institution which receives married women only for confinement. Married women in our city prefer their own rooms, and so generally have comfortable homes that they are rarely willing to enter a charity. The result is that, so far as our knowledge or belief goes, no money devoted to benevolence accomplishes as little for the amount spent as does the foundation of the Preston Retreat. The managers of the Preston Retreat, however, are

not to be blamed for the restriction of their trust to married women, as the condition is imposed by the will of Mr. Preston. The managers of the Women's Hospital of this city have no such excuse: their charter binds them in no way; they are responsible for their own acts; and with cold inhumanity have they shut their doors against the most pitiable of all human beings.

Until, through the efforts of Dr. James W. White and others, some few years since, the State Hospital for Women was made an active reality, there was no hope in this city for a poor woman who had sinned only once, except to go down to the very depths of depravity, when the Magdalen Asylum would welcome her.

The State Hospital has throughout its course met with opposition from the class who shut the doors of other charities. We have seen a letter, signed by five or six prominent clergymen, protesting against the institution being placed in a certain respectable neighborhood, and asking that it be put in a well-known haunt of prostitutes, where the women would be placed under every temptation to plunge into a career of vice. It was a curious commentary upon this letter that the first applicant for relief was a Sunday-school scholar of one of these very gentlemen, who thought his church's atmosphere would be polluted by the hospital being within a few squares of it.

Some years since, puerperal fever broke out suddenly in the State Hospital for Women: two patients died. There were ten in the house awaiting confinement, two being in the very pangs of labor. It was necessary to do something at once. A carriage was secured, and the women taken to the Women's Hospital by the President of the State Hospital; but they were refused admission, although the offer to pay their board was made. Truly, the ways of the unforgiving are hard.

The State Hospital for Women has been

conducted with the most rigid and successful economy; we see by the last report that the average cost per patient, exclusive of rent, was \$3.50 per week; yet it cannot receive a third of the applicants. In the eight years since the opening of the institution, 1800 women have presented themselves, whilst only to about 500 has it been possible to afford shelter and relief; 1300 have had to be cast out, thrown into the whirlpool whose abyss is moral and physical death. Of those admitted to the hospital, it is said, nearly 90 per cent. have been permanently saved from a life of shame. Will our readers keep these facts before wealthy philanthropists?

ALCOHOL.—Every one who has made many microscopic examinations of objects and especially of solutions which have been exposed to the air is familiar with one characteristic of the *saccharo-mycetes* or sugar-fungi,—namely, their ubiquity. The yeast-fungus is always lying in wait to spring into active life when a suitable home is offered it. Under these circumstances it is not surprising that M. A. Müntz, a French chemist, has succeeded in detecting alcohol in rain-, sea-, and river-water, as well as in the general atmosphere and in rich soils. Sewage was found to be very rich in alcohol.

LEADING ARTICLES.

A PREDICTION VERIFIED.

EDITOR OF THE MEDICAL TIMES:

THE disease known as anthrax, *charbon*, *sang de rate*, *milsbrand*, etc., has been demonstrated by so many competent observers in different parts of the world (Davaine, Koch, Pasteur, Greenfield, and many others) to be due to the multiplication in the body of the affected animal of a minute vegetable organism, the *Bacillus anthracis*, that additional testimony will scarcely be deemed necessary to establish the truth of the proposition by those who are familiar with the evidence upon which

it rests, while for those who are not familiar with this evidence the simple facts which I have to relate will have but little weight, as it is only by such extended and carefully conducted experimental researches as have been made by the savants referred to that the exactions of science can be met. However, my single experiment has a special interest, as it shows that the truth stated at the outset of this communication rests upon a sufficiently solid foundation to justify a prediction by Burdon Sanderson of what would happen if a minute quantity of dried blood containing *B. anthracis*, which had been in his possession for seven years, should be introduced beneath the skin of a mouse.

I am indebted to Prof. J. Newell Martin, of Johns Hopkins University, for the specimen which has enabled me to make this experiment, and also for the privilege of reading Dr. Burdon Sanderson's letter accompanying it.

The only portion of this letter which it is necessary to quote is the following:

"I send you the material. I started from it the last experiments I made on this subject. It was then five years old, and consequently is now seven or eight. *I have no doubt that you will find that if worked up with salt solution and injected into a mouse, you will have the spleen after from twenty-four to thirty-six hours enlarged and infiltrated with Bacillus.*"

This prediction has been fully verified by the result of my experiment.

The material referred to was enclosed in a glass tube, and did not, I should judge, weigh more than the sixth part of a grain. As soon as I was able to obtain a living mouse, I added a little salt solution to this material, in accordance with the directions contained in Burdon Sanderson's letter, and injected a few minims of this beneath the skin of the little creature. The injection was made at 2 P.M., June 4. The mouse was alive at 10 A.M., June 5 (Sunday), but upon returning to my laboratory at 3.30 P.M. I found it dead, and upon making a post-mortem examination verified the presence of the bacillus in considerable abundance in the spleen. This bacillus resembles exactly the *Bacillus* of milzbrand as photographed by Koch (*Beiträge zur Biologie der Pflanzen*, Bd. ii., Heft 3), and corresponds with the descriptions given by those who have studied *Bacillus anthracis*.

I may say, in conclusion, that I have not before met with anything like it in the blood or in the spleen of the numerous animals (rabbits or rats) which have been the subjects of my experiments during the past two years (injections of saliva and of various septic fluids. See my special reports to the National Board of Health).

GEO. M. STERNBERG,
Surgeon U.S.A.

BALTIMORE, MD., June 5.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, FEBRUARY 24, 1881.

Dr. M. LONGSTRETH in the chair.

Report of a case of typhoid fever (?) in a child at ten months. By Dr. LONGSTRETH.

DR. LONGSTRETH said that he had been called upon to make the autopsy in this case, and regretted that the history furnished in connection with the specimens was necessarily so imperfect. He was induced to speak of the case as one of typhoid fever solely from the post-mortem evidences. The clinical history, furnished by the attending physician, Dr. Scott, was as follows. The child, female, light mulatto, æt. 10 months, nursed at the breast, taking no other nourishment, but was in the habit of drinking ordinary hydrant-water. She had been strong and well until the present symptoms set in. For two or three days previous to January 6, 1881, the mother had noticed that the child did not play or take the usual notice of things, and was weak, but did not regard her as very sick. On examination, the child was found pale, dull, and could be roused only by extra efforts, and immediately fell asleep again. There was no desire for food, tongue coated white, bowels obstinately constipated, requiring repeated doses of castor oil, and finally an enema, to produce their evacuation. The pulse was about normal in rate, but weak. The skin was dry, but did not give a sensation of heat to the hand. There had been no epistaxis, and the lungs were free from any abnormal physical signs. During the second week the physical signs remained as noted, except that now pain in the abdomen and diarrhoea occurred. The fecal discharges were of grass-green color. Appropriate remedies relieved the pain, and the diarrhoea was easily and promptly checked. The child progressively became weaker, and remained in the same somnolent condition. She was roused and proper and abundant nourishment was taken during the whole course of the illness. Death occurred in the early part of the third week from the commencement of the attack.

Post-mortem Examination, made twenty hours after death.—Rigor mortis firm. Posterior parts of the body discolored. Emaciation marked. The great cavities and their serous lining showed no abnormal conditions.

The right side of the heart was relaxed, and contained considerable fluid blood and soft clots extending into the great vessels connected with the auricle and ventricle. The left side was nearly empty, the left ventricle firmly contracted. The heart-muscle was pale, rather friable, but not fatty. The lungs showed considerable posterior congestion and a few small areas of collapse, but otherwise were normal. The bronchial tubes contained considerable frothy mucus, but the mucous membrane gave no evidence of any inflammatory change, though parts of the respiratory tube were of a reddish color.

The spleen was firm, a little swollen, pale externally and internally, of a dark-reddish hue; its pulp was moderately resistant, and did not exhibit the appearance so constantly seen in the typhoid fever spleen.

The kidneys were nearly typically normal in appearance; the only alteration was a very slight swelling, and an opacity of the cortical portion difficult to differentiate from the general paleness of all the organs.

The liver was pale, its edges very slightly rounded; on section, its tissue was anæmic and appeared homogeneous. The bile in the gall-bladder, moderate in amount, was pale green and mucus-like.

The stomach exhibited a slight swelling of its mucous membrane, and contained, floating in a small amount of fluid, some milk-curds.

The intestine, throughout its extent, exhibited marked alterations. Externally, while generally pale and slightly opaque, at parts reddish patches of coarse injection were seen; but the peritoneum was unchanged.

Its mucous membrane throughout, but more markedly in some parts than in others, showed a distinct but not severe catarrhal inflammatory condition. All the Peyer's patches were more distinct than normal, and, as the examination of them progressively approached the ileo-cæcal valve, they were found more elevated and prominent. The few lower patches were very marked in this state, and their surfaces were uneven, but to the naked eye there was no evident ulcerative destruction of the mucous membrane overlying them. The patches were of unusual length, considered proportionally to the relative size of the intestine. The solitary glands of the ileum, as well as of the colon, were enlarged and prominent, and the mucous membrane of the latter also showed catarrhal changes, but to a less degree than in the small intestine. The appendix vermiformis was swollen, thickened, and gave a feeling of firmness to the finger, but contained only fluid contents.

The mesenteric glands were large and swollen, especially the ileo-cæcal gland.

The contents of the gut throughout were pale yellowish and to a great extent fluid, but some firmer masses of a yellow color were present.

The bladder was empty. The generative organs were normal.

Microscopic Examination.—Portions of the intestine were placed in Müller's fluid overnight, to prevent alteration until sections could be made the following morning by freezing. The Peyer's patches at the time the sections were made showed a much greater prominence than when removed from the body. This change was apparently due to a reduction in the swelling of the surrounding mucous membrane, etc., from the escape of fluid.

The lymph-follicles, as now seen with the microscope on the table, are crowded with the small cell-elements, which at the peripheral portions are arranged in straight bands, while in the central parts the corpuscular elements are heaped together in a confused manner. In some of the follicles their centres are evidently undergoing softening, or at least the fibrillar tissue is less resistant and the unhardened tissue has given way. The prominence or projection of the patch is very great, and, as viewed with a lens of low power, is seen to exceed considerably the thickness of the surrounding intestinal wall. In one of the sections the mucous membrane overlying the follicle is seen to be removed, and the infiltrated follicular tissue is exposed, giving the appearance of a commencing ulcerative destruction.

From this brief note of the microscopic appearances presented by this specimen, it is evident that the conditions resemble those found in unquestionable cases of typhoid fever at certain stages of this disease.

Remarks.—As already remarked, in presenting these specimens to the Society, the clinical history is entirely defective in furnishing a proof, or even a hint, that this case was one of typhoid fever, and it is not claimed that the post-mortem evidence is decisive. However, since the knowledge of the symptoms of this disease occurring at this period of life is very meagre, and the autopsy records of the anatomical changes in the organs are so very few, we are possessed of very insufficient guides to lead us to determination of the nature of the alterations here found.

If the case during life had been attended with prolonged diarrhoea, the presence of this symptom might furnish us with the explanation of the enlargement of the lymph-follicles and the mesenteric glands. The rapid emaciation and the condition of the other organs besides the intestines are not inconsistent with the occurrence of a febrile disease, the presence of which, owing to the absence of a thermometric record, may have been overlooked. The reasons for suggesting the ty-

phoid nature of the disease have already been given.

Dr. TYSON thought the specimen, if not one of typhoid fever, was an anomalous one, in that the agminated glands were enlarged, although in a case of such short duration; for in *chronic* intestinal troubles such a condition of Peyer's patches, as well as of the solitary glands, is not unusual. He would ask Dr. Longstreth whether the surrounding hygienic conditions were such as to suggest any source of infection.

Dr. LONGSTRETH replied that the child was at the breast, but of course must have occasionally had water to drink, which might have been the vehicle of infection if such existed.

Dr. ESKRIDGE said that typhoid fever in the young ran a different course from the disease in the adult. According to his experience, it usually ran its course in two weeks, or less. In one patient under his care, where death resulted from hemorrhage from the bowels during convalescence, the fever had run its course in eleven days. Text-books did not sufficiently emphasize the difference of the symptoms and duration of the fever occurring at the two periods of life mentioned; although within the last two years Dr. Jacobi, of New York, in one of the leading medical journals of his city, had called especial attention to the frequency of typhoid fever in children. He stated that it is milder, that it runs its course more rapidly, that the temperature rises at the beginning and falls at the close more abruptly, that the fever takes on more of the type of remittent (for which it is often mistaken), when it occurs in children. The doctor of late had been much interested in collecting cases of typhoid fever in the adult with irregular temperature records, and related cases to illustrate.

Dr. O'HARA asked whether the other children who had died in this family had shown the same symptoms, at what intervals had the fatal cases occurred, and whether anything like a constant cause could be detected.

Dr. FORMAD inquired as to the possibility of syphilis.

Dr. LONGSTRETH, in reply to the last two speakers, said that, as he had merely made the post-mortem examination, and was unacquainted with the family, he was unable to say anything positively, but as far as syphilis went, the history and absence both of skin eruptions and signs of chronic wasting would indicate its probable absence.

Dr. FORMAD said, in explanation of his question, that the microscopic examination suggests a cirrhotic induration rather than ulceration; in fact, portions look as if the follicles were hypertrophied. Birsch-Hirschfeldt has stated that in congenital syphilis there is this increase of the connective-tissue elements in the lymphatic structures. The present specimen would seem to indicate such a con-

dition, while the characteristic medullary infiltration of typhoid fever is absent.

Dr. NANCREDE related a case of a form of fever such as Dr. Eskridge had described, of which he had seen one case, and had heard from his colleague, Dr. M. J. Lewis, had been quite prevalent last summer. To him, such cases seemed merely what the Germans have described as abortive typhoid. As to the present specimen, he would like to ask if any member present knew the *normal anatomical* appearances presented by the small intestine of a child of eighteen months. He certainly did not, and before we discussed pathological alterations it would be well to have some knowledge of the normal conditions of the parts. It is certainly true that as age advances it becomes more and more difficult to demonstrate Peyer's patches in a state of health. Dr. Longstreth has said that these patches were not so prominent at the post-mortem as now, as the mucous membrane surrounding them was swollen and infiltrated. Their present prominence is due to the effused products having escaped while the tissues have become condensed by the reagent. May it not only be possible, but probable, that these glands are normally as prominent as in the present specimen in children of this age? *A priori*, as we know that they gradually disappear normally with advancing years, it is but fair to infer that, like the thymus and other glands, their appearance a short time after birth is far different from that to be found at but a comparatively slightly later period of life.

Dr. O'HARA asked whether Peyer's patches could not become enlarged from any other cause than typhoid fever.

Dr. TYSON said that experience thus far had shown no other cause to be efficient, although there is no reason why there might not be some other. In the present case the diarrhoea and acuteness of the attack precluded the idea of syphilis. As to the duration of typhoid fever in children, he thought that all authors agreed that it ran a much shorter course in children than in adults, rarely lasting in the former more than two weeks.

Dr. TYSON replied that he was unaware of any such.

Dr. LONGSTRETH asked Dr. Tyson if he was aware of any case of typhoid fever on record in an infant under one year of age.

Cystic tumor of the breast. Presented by

Dr. LONGSTRETH for Dr. PACKARD.

Miss —, æt. about 45, a well-nourished person, and always in enjoyment of good health, with the exception of some functional nervous disorders, perceived during the summer of 1880 a small lump at the upper and inner border of the left mammary gland.

She suffered no pain except after it was handled, but was alarmed by its steady increase in size. It was removed on January 25, 1881; it had reached the size of an Eng-

lish walnut, and proved to be a cyst. During the operation, notwithstanding careful manipulation, the wall gave way at one point, and a quantity of liquid like thin milk was discharged; unfortunately, none of the fluid could be collected for examination. The mammary gland seemed to be healthy, and was left entire.

A microscopic examination was made, the section being taken from the border of the cyst, including a portion of its wall and the adjacent glandular tissue. The cyst-wall was seen to be made up of condensed fibrous tissue, in which the remains of glandular structure were apparent. The near-lying acini or tubules were found slightly dilated and their epithelial lining stained more deeply, and the cells appeared enlarged or hyperplastic, as though from irritation of the adjacent cyst. The other portions of the gland seen in the section showed nothing abnormal.

Remarks.—It is unfortunate that none of the fluid could be collected for examination, but the exigencies of the operation prevented it, and at a later examination of the cyst no fluid was to be found in it. Attention was given to the intima of the cyst-wall, but nothing was discoverable in its structure that gave any evidence of the nature of the cavity or its contained fluid. It seemed probable, from the appearance of the fluid and the condition of the neighboring acini, that the cyst was to be classed as a retention cyst of the mammary gland from (unknown) obstruction of some of its distant tubules.

Dr. TYSON was inclined to consider that the tumor was a "retention cyst."

Cancer of stomach and liver. By Dr. E. T. BRUEN.

These specimens exhibit an encephaloid cancerous growth, embracing the entire anterior wall of the stomach. The largest masses of the new formation are distributed at the junction of the œsophagus with the stomach, although the œsophagus is not involved. The mucous membrane of the stomach is not ulcerated, but the masses are very large, and as felt through the anterior wall they conveyed the idea of a triple layer of figs,—that is, a well-flattened yet decidedly thick and bulky mass, fully four inches in breadth by seven vertically. The growth has caused considerable dilatation of the stomach, especially the cardiac extremity. Extending from the lesser curvature of the stomach can be found a chain of enlarged lymphatic glands running up under the fissure of the liver, between the right and left lobes. This chain of glands commences around the pancreas, but the structure of this gland is not involved.

Cancerous nodules are to be seen in the liver; the largest nodule, in the left lobe. In the pleura of the right side nodules are found which microscopic examination has shown to be cancerous.

I also exhibit a portion of the skull, with a

developed nodule in the periosteum, of the size of a walnut.

These specimens were removed from the body of a man 40 years of age, with a good family record, without history of cancer or scrofula.

The sequence of the cancerous development is as follows. In June last, about five months prior to the date of his death, the tumor of the stomach developed. Six weeks before death, the tumor in the liver was diagnosed; some three weeks before his death, the nodules in the pleura were discovered.

The clinical history is a recital of the usual symptoms of similar conditions. It is interesting to note that vomiting was never a symptom unless very inappropriate food was used; there was never vomiting of blood, but large amounts of gas were frequently passed per mouth and anus. There was no constipation. To explain this absence of frequently-expected symptoms, I would note that the pylorus was not involved; thus vomiting was not induced, because the contents of the stomach could readily pass into the intestine; and, as the liver was only involved in the later history of the case, intestinal digestion was not impaired.

Pain, however, was a prominent symptom, and the suffering was much increased by the developments in the pleura.

Another interesting symptom was a total paraplegia. The power of motion in the legs was abolished, and there was no control over the bladder or rectum. This paralysis appeared some four weeks before death. It fully developed itself in about one week, leading me to suspect that a similar change would be found in the membranes of the cord to that noticed in the pleura. At the autopsy the cord was examined in its entirety, and nothing abnormal could be detected. In fact, the cord has been cut into sections and is used to demonstrate the normal histology of that tissue to the class at the University of Pennsylvania.

A loud systolic bruit could be heard over the region of the aorta, audible just below the ensiform cartilage anteriorly, diminishing as the aorta passed downward. It was heard posteriorly over the dorsal spine quite distinctly. This bruit was not affected when the hand-and-knee position was assumed, or when an effort was made to draw the tumor downward into one or other iliac region, which could be partially accomplished. The persistence of murmur was probably owing to the constant pressure of this large mass on the aorta; and, owing to the fact that most of the growth affects the cardiac end of the stomach, it could not be dragged away from the vessel as one could drag a tumor in some other part of the stomach.

Yet, for all this, I felt I could exclude aneurism even in the early stages of the growth,

since aneurismal pressure-signs were absent, and there were no evidences of systemic conditions which predispose to disease of the arterial coats, such as syphilis, alcoholism, rheumatism, and the like; and these evidences I regard as of ultimate importance.

Finally, I would say that the movable character of the tumor above referred to, and the absence of symptoms of intestinal indigestion, were important evidences that the location of the primary tumor was in the stomach. I think you will agree that cancers of the anterior wall, since they grow backward and inward, are not necessarily more prominent to palpation during life than are tumors of the posterior wall of the stomach. This tumor seemed to be situated just beneath the skin, so superficial did it seem during life. But I have examined cases in which the tumors seemed equally superficial during life, yet autopsy revealed the location of the disease in the posterior wall.

Sections of the cerebral ganglia, with remarks on their anatomy and lesions. Presented by Dr. CHARLES K. MILLS.

The specimens exhibited, nine in number, were—(1) transverse and vertical sections; (2) longitudinal and vertical sections; and (3) horizontal sections of the ganglia. The preparations were not for microscopical study, but were for the purpose of illustrating some points in connection with the coarse examination of the brain, with the view of accurately localizing and recording lesions. The following is an abstract of the remarks made by Dr. Mills:

Although physicians seem lately to have awakened to the importance of carefully describing the limits of cortical lesions, they do not appear to be as fully alive to the equally important matter of definitely localizing lesions of the deep parts of the brain. By studying transverse, longitudinal, and horizontal sections of the cerebral hemispheres, one can soon obtain a clear idea of the size, shape, and normal appearances of the ganglia, and of the intervening and surrounding white matter. On the whole, perhaps, vertico-transverse sections will be the most available and lead to the least confusion in making post-mortem examinations. The profession has become familiar with the appearances presented by such sections from the plates in the works of Charcot, Ferrier, and others. The appearances of longitudinal and horizontal sections are not so well known. In the *Annals of the Anatomical and Surgical Society of Brooklyn* for January, 1880, and in *Brain* for July, 1880, Prof. J. C. Dalton, of New York, has published papers on the *corpus striatum*, from a study of which many useful points can be learned with reference to longitudinal and horizontal sections. I show you sections similar to those figured in these articles, and will quote his remarks on horizontal sections: "In horizontal sections of the

brain, the size and form of the cerebral ganglia vary greatly according to the level at which the section is made. At the level of the corpus callosum only a little of the arched portion of the corpus striatum is exposed, and none of the lenticular nucleus is visible. Somewhat below this, at the level of the fornix, the arched portion of the corpus striatum disappears, but there is a large oval section of the head in front, and a small one of the surcingle behind. Lower still the lenticular nucleus comes into view, separated from the head of the corpus striatum by the distinctly marked anterior prolongation of the internal capsule. At the level of the anterior commissure the lenticular nucleus and the head of the corpus striatum begin to fuse with each other, owing to the partial disappearance of the internal capsule between them. At this level the head of the corpus striatum is much reduced in size and altered in shape. The lenticular nucleus occupies a position outside and behind it; and still farther back is the section of the surcingle, which is here beginning to run downward and forward, along the roof of the inferior horn of the ventricle. At a lower section still, the head of the corpus striatum would be united with the cortical convolutions in front of the Sylvian fissure, and the surcingle with the gray substance of the amygdala."

Attention might be called to a few points of special interest.

An erroneous idea of the exact position and relations of the ganglia may result from always studying brains after they have been removed from the skull. The superior surfaces of the intra-ventricular striate body and of the optic thalamus do not present a horizontal plane when the brain is in position in the skull, as they appear to do after it has been removed. Cutting into the lateral ventricles, with the brain still resting on the floor of the skull, it will be found that the faces of these ganglia are nearly perpendicular.

The slight depth of a large portion of the caudate nucleus might, perhaps, mislead in careless autopsies. At the head of this nucleus, where it partly blends with the lenticular body, the depth of gray matter is considerable, but it is slight as you go backward, ranging, in some measurements which I have made, from one-eighth to one-third of an inch.

When examining the lenticular nucleus, the difference in color of its different segments should be borne in mind. These are very marked, and, through ignorance of them, I have seen the error made of supposing that a normal lenticular ganglion was invaded by a large sclerotic nodule. On transverse sections in the anterior third a uniform grayish tint is presented, but in the posterior two thirds, two, and sometimes three, colors or shades can be made out,—one the grayish hue alluded to, and the others yellowish or yellowish-brown. On making a central longitudinal incision,

the uniform gray tint of the heads both of the caudate and lenticular bodies is continued backward the whole length of the section, gradually tapering, however, and passing beneath the yellowish segments. These appearances are given by the two outer segments seen in the transverse cut. In infancy the differences in color between the parts of the lenticular nucleus are not so well marked as they are later in life.

We cannot be too particular in localizing lesions, and especially isolated lesions, of the ganglia and tracts. By so doing we may help to solve the problem—now so obscure—of the functions of these parts. The landmarks, as I have tried to show, being plain, this localization is not in reality a difficult matter. In some respects, indeed, it is less troublesome to locate and record lesions in the ganglia and capsules than in the convolutions, because in the latter we may have confusing secondary and tertiary deviations from the usual forms. In considering isolated lesions it must not be forgotten that they may exert pressure on surrounding regions.

According to Nothnagel (Ziemssen's *Cyclopædia*, vol. xii. p. 145), "lesions in the main cerebral ganglia from which spring the motor tracts of the crura cerebri, the *nucleus lenticularis* and the *corpus striatum* (*nucleus caudatus*), inasmuch as they are the most common of all, give rise to the most familiar group of symptoms." It seems to me, rather, that these lesions have taught us less that is exact than those of almost any other well-studied region of the brain, because, in the first place, absolutely isolated lesions of the ganglia and capsules are by no means common, and, secondly, because of the careless manner of making and recording lesions of these regions. It is probable that in the ganglia we have, in some way, representatives of each of the differentiated centres of the cortex. Certainly, as suggested by Charcot, the three gray nuclei of the lenticular body may be so many centres endowed with distinct properties and functions.

PHILADELPHIA ACADEMY OF SURGERY.

STATED MEETING OF MAY 2, 1881.

DR. R. J. LEVIS, Vice-President, in the Chair.

LARGE VESICAL CALCULUS.

DR. THOMAS G. MORTON exhibited a calculus weighing four and one-half ounces, and measuring six and one-half inches in circumference, which he had removed by a transverse vaginal incision from the bladder of a lady seventy-nine years of age. She had presented symptoms of vesical disease for forty years, but had never allowed an examination to be made. The stone was so large that it could not be turned within the bladder, and considerable difficulty was experienced

by the operator in extracting it, as the instruments at hand were better adapted to the extraction of a small stone through the urethra. After the stone was removed, silver sutures were introduced, and the patient made a rapid recovery.

TWO CASES OF EXCISION OF PORTIONS OF THE INFERIOR DENTAL NERVE, FOR NEURALGIA.

Dr. Thomas G. Morton read the histories of the following cases:

Case I.—E. H., aged seventy-one, gave the following history. About nine years ago, began to have pain on the left side of the lower jaw. The first attack came on at dinner; it lasted for an instant only, and no further pain was felt for several days; it then recurred, and since, at short intervals, the attack has been very severe; generally came on during eating, but after moving the muscles of the jaw the pain subsided; a frequent cause of pain was from the use of the tooth-brush, talking, swallowing,—in fact, any movement of the jaw; although the attacks of pain would appear at night, disturbing sleep, not infrequently several times during the night. During the earlier part of the past nine years of suffering there were times—perhaps two or three—when there was an absence of pain for several weeks, but of late years the distress has been nearly continuous. Had tried all remedies suggested, without any relief. The pain seemed to originate at the angle of the jaw, and generally progressed forward into the teeth; now and then it would shoot into the temporal and facial region. Several molar teeth were removed on account of the neuralgia, but not the slightest improvement was observed. During the past few years, and especially the last twelve or fifteen months, the agony was great, causing loss of appetite, flesh, and sleep; and, indeed, the suffering made inroad upon the general nervous system.

In consultation with Dr. Agnew, it was agreed to excise a portion of the inferior dental nerve, and to make the section just above the jaw-angle. There was no abnormality of the jaw as far as could be observed, save a contraction incident to age and from the extraction of teeth. The diagnosis made was pressure from this upon the nerve-canal.

March 21.—The bone was exposed and the trephine was applied. As soon as the instrument had penetrated the cancellated structure, the circular portion of bone was removed, and the nerve and artery were seen lying directly in their usual course; the former was lifted on a hook, and after being thoroughly stretched half an inch was excised. There was no bleeding, for the artery was not injured. The wound was brought together with silver sutures; these were removed on the fifth day. In a fortnight E. H. was out driving and quite well. A few days after the operation he experienced a few (perhaps three

or four) twinges of pain, but momentary. A month has elapsed since this, and the relief has been entire; he has had no return, even of a twinge, as he writes me:

"I can eat, masticate, and swallow with a comfort and confidence that I have not known for years. My health, especially my nervous force, has much improved since the removal of the nerve."

The second case was that of a gentleman aged fifty-six, of this city. His symptoms correspond so nearly to those of the former case that the account need not be repeated. The length of time, however, had been much shorter, the duration of pain extending only through three or four years. He had tried every conceivable form of treatment without any effect other than the injury of general health from anodynes. The pain in this case was on the right side, and in removing the section of bone some points of special interest occurred, which are perhaps worthy of record.

April 13.—The trephine was applied at the usual place, midway between the upper and lower edge of the jaw, above the angle; and after gaining what seemed to be the centre of the structure the nerve could not be found, nor any evidence of the canal, nor was there any special hemorrhage, so that I reapplied the trephine, and a few turns carried the instrument through the entire thickness of the jaw. A careful survey showed the nerve much out of its usual course; it was found with a probe at the very uppermost part of the sawed section, in conjunction with the artery; a probe was passed around it, and it was drawn down and cut off. The artery, which was pricked, was tied in two places by ligature, and the wound was brought together by silver sutures. An excellent recovery followed, with an entire relief from the neuralgia, the patient being in a fortnight attending to out-door business, although the wound had not yet closed.

In both cases there was complete anæsthesia extending along the jaw and involving the soft tissues to the middle of the lower lip.

Dr. J. Ewing Mears stated that he had had some experience in the treatment of neuralgia of the trifacial nerve, and he thought it important to determine, if possible, before submitting the patient to operation, whether the lesion was central or peripheral. He had observed a number of cases in which excision of the nerve had been performed and the relief had been of a transient character. In operations which he had performed of removal of the alveolar border of the jaw, for the relief of alveolar neuralgia, permanent benefit had not been obtained. In one case he had cut into the inferior dental canal, and had removed a portion of the nerve with the roots of a tooth which were found imbedded in the jaw. The operation did not permanently relieve the pain. Other cases he had treated by long-continued medication, and

the results were much more satisfactory than had been obtained by operations.

Dr. Morton said that in one of his cases the irritation certainly seemed to be peripheral, because it was produced by pressure upon a certain spot.

The patient is, at any rate, greatly benefited at the present time, though the neuralgia may recur. He had removed a portion of the second branch of the fifth nerve very often, and, having watched the cases, found them free from pain long after the operation. He thought that union of the divided nerve would not be likely to occur after operating on the inferior dental nerve, because the canal would be obliterated.

Dr. J. M. Barton had treated one of the cases mentioned by Dr. Morton by full doses of the usual remedies, and on account of failure to give relief had advised operation, which the patient at that time refused.

In operating himself, he used a much smaller trephine than Dr. Morton,—an instrument a half inch in diameter being found quite sufficient,—and had found the nerve to be nearer the upper edge of the jaw than the median line, especially in individuals who had lost their teeth, and in whom the alveolar process was absorbed, and who so often are the victims of this painful malady.

Pain returned in some cases for a short time after the operation, but then disappeared, which suggested that the disease was peripheral and the temporary neuralgic pain following was due to the irritation of the diseased portion by the operation, confirming the diagnosis of the disease being peripheral, and making the prognosis of a cure more favorable. When the neuralgia depends on central causes, Nussbaum's operation of ligation of the carotid artery may be proper. Fourteen cases of operation for this cause have been reported, twelve in Europe and two in America. Of these thirteen recovered and one died. Of the thirteen recoveries six were cured, four temporarily improved, one not benefited.

The operation was performed last summer at the German Hospital in this city, by my colleague Dr. F. H. Gross, on a patient in whom all three branches on one side were violently affected. Since the operation the patient has had no pain in the first and second branches, and only an occasional twinge in the inferior dental.

Dr. Mears would not oppose operation in all cases, but his experience convinced him that the results were not as good as usually believed. In view of this fact he thought, in order to obtain more decided effects, operations should include more than excision of the nerve. The branches of the three divisions of the fifth nerve which are involved in the neuralgic condition escape to the surface through osseous rings or canals, each accompanied by an artery and a vein. Assuming

localized pressure as the cause of the affection, this can occur, external to the nerve proper, by encroachments upon the calibre of the canals, as the result of inflammatory or structural changes in the bone-tissue, or by an hyperæmic condition of either artery or vein. Within the nerve abnormal fulness of the minute capillary vessels which permeate its structure could exert sufficient pressure here, as elsewhere in the body. Of these conditions bony constriction must be regarded as an exceedingly rare occurrence, whilst congestions of the accompanying artery or vein, or of the nerve-vessels themselves, may be frequently present. He would suggest, therefore, in all cases where excision of the nerve is performed, that the accompanying artery should be ligated, with a view to remove a probable exciting cause. He was aware of the good results which had followed ligation of the common carotid artery in trifacial neuralgias. This procedure cannot be employed in all cases, owing to its gravity, whilst the ligation of the artery in the canal increases in no respects the risks of the original operation.

Dr. R. J. Levis said that Dr. Morton's paper recalled a similar case in his own practice where the trephine had perforated a shrunken jaw-bone without any untoward symptom following. He had operated in four cases, and in only one was the success permanent. This patient had shown marked peripheral sensitiveness. (Since the meeting a letter from this patient's physician has been received by Dr. Levis, stating that the operation, which was done many years ago, was followed by relief for only a short time, and that the woman is at present a great sufferer from the original neuralgia.) He always used a very small trephine, and would expect the nerve to seem comparatively highly placed in a shrunken edentulous jaw. Failure had always occurred in his experience after Gross's operation of cutting away the alveolar process in case of neuralgia in the toothless jaws of old subjects. Recently, in neuralgia of the alveolar processes, he had dissected up the periosteum by incisions through the gum, detaching it freely from the surface of the superior maxillary bone in the endeavor to relieve the pain; but the result was not satisfactory.

Dr. De F. Willard recollected a case where the pain returned subsequent to operation, but about a year afterwards disappeared, and has not recurred, though many years have elapsed.

OBSURE CASE OF ENLARGEMENT OF THE HEAD OF THE HUMERUS.

Dr. J. M. Barton presented a child of six years, from whose parents he could get no distinct history, with general enlargement of the upper extremity of the right humerus. Pain was said to have been present for two

months, and there was muscular ankylosis of the shoulder-joint. Some of the symptoms suggested central sarcoma of the head of the humerus; but Dr. Barton desired the opinion of the Fellows as to the diagnosis, and asked whether any operative step, such as trephining, scraping out the cavity, if such were found, or excision, would be warranted in such an obscure affection.

Dr. T. G. Morton would be inclined to wait, and then possibly make an incision into the bone with the view of finding a scrofulous abscess.

Dr. O. H. Allis said the same case had applied to him about three weeks previously, with great pain and fulness in front of the shoulder, which was so acute that the child would scarcely allow the shoulder to be touched. He had applied a blister with the result of relieving pain, and had ordered a second one to be used upon the other side of the joint. The condition of the case was quite different now from what it was when last seen by him in his dispensary service.

Dr. John H. Packard thought the subsequent history of the patient would prove highly interesting. The existence of no joint-involvement and no appearance of periosteal abscess, coupled with the facts that tumors of bone are rare at such an early age, and that abscess of bone would hardly exist with as little pain as was at present manifested, rendered the case very obscure. The child, to his mind, presented some of the appearances usually associated with scrofulous affections.

PULSATING TUMOR AT ELBOW CURED BY LIGATION OF BRACHIAL ARTERY.

Dr. R. J. Levis exhibited the patient, who was shown at the November meeting of last year (1880) with an obscure pulsating tumor below the right elbow. He had subsequently ligated the brachial artery at the Pennsylvania Hospital, and the rapid cure of the case proved the tumor to have been aneurismal. There was now to be felt near the median line of the forearm a nodule which was evidently the shrunken sac.

Dr. Mears called attention to the fact that now the sac seemed to be at the radial side of the forearm, though in November the tumor was believed, if an aneurism, to be connected with the ulnar artery. It may have been at the lower part of the brachial. Both radial and ulnar now pulsated at the wrist, and the radial seemed stronger than the ulnar.

SPECIMEN OF ANCHYLOSIS OF ELBOW.

Dr. John B. Roberts presented a specimen obtained from his dissecting-room at the Philadelphia School of Anatomy, illustrating bony ankylosis of the elbow, due apparently to partial luxation backward of the ulna, associated with fracture of the olecranon process.

The altered position of the carpal ends of the radius and ulna, due to the displacement of the upper end of the ulna, was especially pointed out.

JOHN B. ROBERTS,
Recorder.

REVIEWS AND BOOK NOTICES.

ON THE ANTAGONISM BETWEEN MEDICINES AND BETWEEN REMEDIES AND DISEASE. Cartwright Lectures for 1880. By ROBERTS BARTHOLOW, M.D. New York, D. Appleton & Co., 1881.

Probably most of our readers will consider that we have awarded this treatise high praise when we say that it seems to us the most carefully written, best thought-out, and least dogmatic work which we have yet read from the pen of its author. It is indeed a very praiseworthy book; not an original research, indeed, but, as a *résumé* of the world's work upon the subject, the best that has hitherto been published in any language. It is composed of six lectures,—the first chiefly occupied with a history of the subject and a preliminary discussion of terms, etc.; the last, with a consideration of the relations of remedies to disease; whilst the intermediate four chapters are devoted to individual antagonisms. In a notice like the present we cannot, of course, follow discussions in detail; but we desire to call especial attention to the term "antagonism of remedies," because the common use of it seems to us to lead to inaccurate thinking as well as writing. The term "physiological antidotism of remedies" has been suggested and by some used as a substitute for antagonism, but is declined by Prof. Bartholow. It seems to us very clear that both terms should be employed as having different meanings. It is absurd, for instance, to say that one remedy is antagonistic to a second, but that the second is not antagonistic to the first; whilst it is perfectly conceivable—indeed, does happen—that one medicine is antidotal to a second, which is not in turn antidotal to the first. Suppose poison A kills by sweating into fatal exhaustion, poison B arrests sweat-secretion, but kills in overdose by paralyzing the centres of respiration: it is apparent that B would be antidotal to A, whilst in poisoning by B A would be of no service.

On page 69 of Prof. Bartholow's book we read: "... but chloral is an antagonist to strychnia poisoning, rather than strychnia is an antagonist to chloral poisoning." By substituting "antidotal in" for "antagonist to," the sentence becomes logical. This distinction is not merely of verbal importance: clear speaking and clear thinking are bound together. Indeed, very many of the researches upon so-called antagonisms throw little light upon the science of the question, however valuable they may be as studies of practical antidotism. When investigators generally recognize the

difference in the two terms, we shall have made one step forward.

LECTURES ON SYPHILIS, DELIVERED AT THE HARVEIAN SOCIETY, December, 1876, by JAMES R. LANE, F.R.C.S., Surgeon to St. Mary's Hospital, and Lecturer on Surgery, Consulting Surgeon to the London Lock-Hospital. Second Edition. London, J. & A. Churchill, 1881. Fcp. octavo, 95 pp.

This little book is one of the most entertaining and instructive upon its subject which we have ever read. Mr. Lane has had in view to trace as concisely as possible the progress made of late years in the investigation of syphilitic venereal disease, to point out the generally accepted views of the present time and the principal points of divergence. This he does in a clear and satisfactory manner, describing the discovery of the non-identity of gonorrhoea and syphilis, the differentiation of the chancroid, the "unity" and "duality" theories, syphilization, phagedæna, reinfection, contagion of secondary syphilis, contagion by syphilitic blood, vaccino-syphilis, contagion of secretions of syphilitic patients, hereditary syphilis, visceral syphilis, the modern treatment of the disease, and its legislative prevention. Every physician who desires to be fully informed regarding the progress of medicine, or who wishes to refresh his memory as to the essential points in connection with syphilis, should obtain this little book and master its contents. Its market-price is not high, but it is worth its weight in gold.

A. V. H.

DISEASES OF THE JOINTS. By RICHARD BARWELL, F.R.C.S. New York, Wm. Wood & Co.

To one who wishes to add to his library a useful work on diseases of the joints, this book can be recommended. It bears upon every page indications of careful, deliberate preparation. All that could make one master of his subject has been brought under tribute, and the reader becomes more and more impressed with the real value of the work the farther he proceeds in it. It is a book, however, that must be studied,—and studied carefully: it cannot be simply read. Neither can it be snatched up for examination upon a particular point with the view of getting the author's views. The author treats the subject as a whole, and he who would understand him on any one subdivision must pass in careful review all the preceding chapters. It is, therefore, not only unfair, but in this instance especially unjust, to criticise the views expressed at particular points,—since to be full at all points would require endless and tiresome repetition.

The work is abreast of the most modern pathology and therapeutics, and if lacking anywhere it is in surgical details. As these, however, may be found in any general work on surgery, the author has not felt it necessary to be more explicit.

We regret that so valuable a work should reveal its chief defects in the style of its author. After qualifying himself so nobly for his task, it is inexcusable that one so abundantly competent to write good—and by this we mean simple—English should mar a life-work by original word-building and by sentences rendered the more obscure by violation of the first principles of composition.

This, however, is the worst that can be said of the book. The kernel is in the nut, and will richly repay the labor to come at it. A.

A MANUAL OF THE PRACTICE OF MEDICINE.

By H. C. MOIR, M.D.

This work is a compilation, and is a good work of its class, but, in our opinion, it will be a bright day for the medical world when the class for which it is written is extinct. If monographs and treatises on medicine come to be entitled studies or treatises on morbid physiology, original thought will be stimulated, principles will be established of value to direct in special exigencies, and routine methods of work branded as distinctly inferior. The idea prevalent among the laity is fostered by such works as this, viz., that the medical man is near akin to the barbers and alchemists of olden times, that he has a definite recipe for every demand, and the idea is covered up that he is practising on the basis of scientific investigation combined with shrewd observation. But if the lame and the halt must abide, the crutch provided by this book is trustworthy and reliable. The book is a catalogue or dictionary of medicine, etiology, symptomatology, and treatment being each considered in a representative style; and it is worthy of especial mention that the therapeutics advised are in accord with most standard authority. But we cannot but think a book incomplete even as a dictionary when we can read, as on page 376, that digitalis is advised in chronic Bright's disease as a diuretic, and yet its properties as a stimulant to the heart and circulation are not dwelt on sufficiently to guide the venturesome practitioner in his watch for the dreaded symptoms of its toxic action; and this instance is cited as typical, in our opinion, of a defect in method of teaching.

CLINICAL LECTURES ON THE PHYSIOLOGICAL PATHOLOGY AND TREATMENT OF SYPHILIS.

By FESSENDEN N. OTIS, M.D., Clinical Professor of Genito-Urinary Diseases in the College of Physicians and Surgeons, New York, etc. New York, G. P. Putnam's Sons, 1881. Octavo, pp. xvi, 116.

These lectures originally appeared in the columns of the *Boston Medical and Surgical Journal*. They are the expansion and amplification of the views of the author published ten years ago, with such modifications as experience has suggested. We can best characterize their scope by quoting a passage from a review (in the *Lancet*) of Dr. Otis's earlier

papers, which he himself adopts: "His views are not based upon the results of any experiments, or new facts, or on the unravelling of observations. They consist mainly of deductions drawn from a close and elaborate reasoning on the acknowledged features of syphilis, in connection with the latest doctrines and hypotheses of certain pathological teachers." Want of space forbids our entering into the details of Dr. Otis's speculations, which must have an interest, however, for every student of—what we may term, in contradistinction to the more routine pickling of diseased organs and cutting and mounting of microscopic specimens—"transcendental pathology." We could wish, however, for a more lucid style, and for the omission of clinical detail, which, though very interesting in itself, distracts the attention from the main course of the argument. A. V. H.

DE LA PHTHISIE PULMONAIRE ET DE SA CURABILITÉ. Par JEAN-LOUIS-SIMON JOLY, Docteur en Médecine. Paris, J. B. Baillière et Fils.

"As our medical practice dates twelve years, and the cases of cure we have obtained are quite numerous, we will only quote the most important observations." These words, on page 70 of this pamphlet, inspire us with enthusiasm, and our fancy depicts emoluments palling the fortunes of the venders of Schenck's Pulmonic Syrup or Jayne's Expectorant; but as we read of the curative influences of powders evolved from "la calcination de petits os de volailles," and of cod-liver oil, we recall that in the shadowy past, in our own land, these measures have been cautiously tried by some bold spirits. For cough our instructor would advise opium, codeia, pills of iodoform; for fever, aconite; for diarrhoea, liquid diet; as tonics, arsenic and strychnia. The *coup de main* is diet. This must be vegetable food strictly, since it is more acceptable to the stomach than animal food, and also vastly superior, because it contains the salts most desirable to secure and encapsulate the tubercle. As examples, French beans and wheat are cited, eggs and milk are approved, and an analysis of these unique foods is appended. Our author's belief is firm that phthisis is tubercular and develops from diathetic predisposition, scrofula playing a foremost part; excessive lactation in women, the fevers, diabetes, and exhausting conditions have a share as predisposing conditions. He disbelieves in the inflammatory origin of phthisis, although he admits a pleurisy is the antecedent of many cases of tubercular phthisis. In climate, the extreme cold of Lapland or an African sun seem to be his Utopia for the phthical, large, airy, sunny rooms for those who cannot leave home. The thought will intrude itself, "Is there nothing new under the sun?"

E. T. B.

DRUGS THAT ENSLAVE. THE OPIUM, MORPHINE, CHLORAL, AND HASCHISCH HABITS. By H. H. KANE, M.D. Philadelphia, Presley Blakiston, 1881.

This is a small octavo book of about two hundred pages, in which are discussed with much detail the various questions connected with the habitual use of the narcotics named in the title-page. The most novel and by far the most interesting portion of the work is that in which chloral is dealt with, the conclusion being reached that it is the most dangerous agent of the class. We notice a rather remarkable statement in regard to the influence of opium. It is stated, "A lady who had used morphine by the mouth for sixteen years found her *virile power* during and at the end of that time in no way impaired; if anything, it was increased." We suppose the virile power of a lady must be her husband, either in general or in a particular part. Now, that the husband, either as a whole or in a member, should be increased by the use of opium by the wife, strikes us as worthy of attention.

Usually the English of Dr. Kane is good, and the book not only covers very well its allotted territory, but is more of a contribution to medical literature than are many more pretentious rivals.

APHORISMS IN FRACTURE. By R. O. COWLING, A.M., M.D., Professor of Principles and Practice of Medicine.

In the form of aphorism—i.e., in pithy, clear, but comprehensive sentences—the author has said scores of useful things. Had he been content to employ his skill on the general truisms of the subject, his little pamphlet would have been incapable of harm. As it is, he has essayed the *treatment of the whole domain of fractures in ten pages*, and in this not only renders his work valueless, but even worse,—harmful.

We have nothing to say when men offer to teach music, painting, or a modern language in ten lessons; but when primers step forward and speak authoritatively upon a subject that on the one hand may cripple a patient for life, and on the other filch two thousand four hundred and fifty dollars from the treasury of the doctor (as lately occurred in Erie, Pennsylvania), we cannot regard the matter as a harmless joke, but must urge a protest against all such pretensions to medical teaching.

THE DIAGNOSIS OF DISEASES OF THE SPINAL CORD. By W. R. GOWERS, M.D. Second Edition. Philadelphia, Presley Blakiston, 1881.

Most of our readers are no doubt familiar enough with the first edition of this book to know that in its eighty-four pages is contained an excellent epitome of our knowledge concerning spinal cord diseases. Carefully and clearly written, it constitutes, in its original

form, a valuable brochure for the practitioner's library; in its present revised shape it is certainly no less satisfactory, and in some parts, especially in the discussion of clonic and tendon reflex, decidedly more satisfactory, than it was as first penned.

A GUIDE TO THE CLINICAL EXAMINATION OF PATIENTS AND THE DIAGNOSIS OF DISEASE. By RICHARD HAGAN, Privat-Dozent to the University of Leipsic. Translated by G. E. GRAMM, M.D. New York and Philadelphia, Boericke & Tafel.

This work represents the need of the younger portion of the profession and the students of medicine, but it gives them but a stone. It is too much condensed: in the effort to embrace all the field, it is practically but a slightly enlarged medical dictionary. Fifteen lines are devoted to aneurism, and no mention of symptoms save murmur and dulness over the course of the aorta. In diseases of the brain and its membranes it is much too laconic. The section on the examination of the urine is, relatively, the most comprehensive in the book, thirty pages being devoted to it; while but thirty lines are given to typhoid fever. The physical diagnosis is open to the same criticism: it is good so far as it goes, but the work does not compare favorably with books of its class, such as "Elements of Practical Medicine," by Alfred Carter, M.D., lately published by Presley Blakiston, of this city.

E. T. B.

THE HEART AND ITS FUNCTION. (A "Health Primer.") New York, D. Appleton & Co., 1881.

"A faint cold fear thrills through my veins
That almost freezes up the heat of life.

This horrid image doth unfix my hair
And make my seated heart knock at my ribs
Against the law of nature."

Fancy calls to mind similar, though less poetic, laments from students after concluding their first course in physiology, and fancy pictures a similar state of mind in the dabbler in medicine who is buried in primers. A study of physiology affords a basis upon which a physician can advantageously advise his patient, but a primer renders a patient self-opinionated.

E. T. B.

WHAT TO DO FIRST. By CHARLES W. DULLES, M.D. Philadelphia, Presley Blakiston.

A household proverb, "Necessity is the mother of invention," is set at naught by this work. She is a matron of essentially American stock, and the brains of her offspring are being whittled into imbecility by popular adaptations of medical science, of which this work is a type; or else they become paralyzed into inaction because individuals become unable to dissect "what to do first" from the accumulation of technical knowledge at their disposal.

GLEANINGS FROM EXCHANGES.

IMPACTED FOREIGN BODIES IN THE EXTERNAL AUDITORY MEATUS.—Dr. Francis H. Brown (*American Journal of Otology*, vol. iii., 1881, p. 29) says that, judging from the remarks of some authors, the meatus auditorius is looked upon as a *terra incognita*, much as the colon or the pleural cavity would be, and its investigation to be entered on as we should that of any of the inner organs of the body. Every practitioner should, on the contrary, recognize the fact that the entire passage of the outer ear is within his sight, and that the treatment of its diseases should be governed by the same rules which would dictate his care of any other portion of the body's surface.

After speaking of the various instruments in common use for the removal of foreign bodies from the external auditory meatus, Dr. Brown says the point he wishes to make is that tightly-impacted bodies in the ear *must* be removed; that the practice of allowing them to rest even in cases where no apparent and immediate irritation and inflammatory action are present does not offer assurance that subsequent trouble will not arise, and, in fact, at some time or other, with the accumulation of cerumen in the ear, with the access of cold, or by some other means, the meatus is very likely to take on inflammatory action, in which case the integrity of the middle ear may be jeopardized. If the body is firmly impacted in the ear from the first, its very presence and pressure induce cedema of the meatus, and the longer it remains, the more unsatisfactory will be the attempt to remove it. A sort of burr is often formed, both before and behind the body, caused by the cedema to which the stoppage of circulation gives rise, and this may obscure the body from view. As an example of what may be expected when such foreign bodies are allowed to remain, Mr. Hutchinson speaks of a child with a locust-bean in its ear which could not be removed. The bean soon swelled, and filled the cavity. A week later the child was feverish, had pains in the head, then paralysis of the portio dura came on. Dr. Brown considers the Tiemann bullet forceps the best instrument for extracting, and he gives a note of a case in which an impacted kernel of corn was removed by this instrument, the patient being placed under ether rather than allow the seed to remain and swell within the meatus.

THE INFLUENCE OF TEMPERATURE ON ABSORPTION.—Sasselsky (*Lancet*, vol. i., 1881, p. 637; from *St. Petersburg. Med. Wochens.*) has published the results of some observations on the influence of temperature on the absorption of drugs. These were introduced by the mouth, the rectum, or by hypodermic injection, in the case of persons in good health,

and of others suffering from various diseases. Iodide of potassium, salicylic acid, ferrocyanide of potassium, and hydrochlorate of quinine were given in solution by the mouth and rectum, care being taken that each viscus was previously empty. The period after administration at which the drug could be detected in the urine was taken as the indication of the rapidity of absorption. For hypodermic injection, solutions of iodide of potassium and ferrocyanide of potassium were employed. It was uniformly found that, when given by the mouth or rectum, the higher the temperature of the solution the more rapidly it was eliminated, the results varying from two to forty minutes, and depending somewhat on the individual conditions of the patients. The results in hypodermic injection were doubtful. Manassein has suggested that warm liquids cause a more intense hyperæmia of the mucous membrane, and hence are absorbed more quickly. On the other hand, cold liquids cause an initial contraction of the vessels, which has the effect of delaying absorption.

DANGERS OF CHLORATE OF POTASSIUM EXAGGERATED.—Dr. Harkin, in a letter to the *Medical Times and Gazette* (vol. i., 1881, p. 413) challenges the correctness of Dr. Jacobi's statements regarding the dangers of using chlorate of potassium. He says he has prescribed the chlorate through the medium of the maternal circulation, to the languishing fœtus in utero, with the greatest advantage; to the baby and the nursing mother (to the former directly as well as through the instrumentality of the mammary secretion); to the child in marasmus and struma; to the anæmic and menorrhagic female, and to sufferers from every phase of the hemorrhagic diathesis; in skin ailments from acne punctata to the boil and carbuncle,—in fact, to patients suffering from every class of disease depending upon debility or subaëration, from the time of childhood to the climacteric period of existence,—and he has never witnessed a single instance of permanent injury to health, much less to life. It may disagree, perhaps, in one case in a thousand, but here gives warning by a feeling of approaching dysuria, and the remedy can be at once discontinued before any real injury accrues. As to nephritis, Dr. Harkin remembers only a single case that at all approached this condition. Here a young lady suffering from phthisis had an attack of painful strangury, lasting some hours, but easily relieved by the ordinary means of stupes, hot baths, etc. Dr. Cutter, of New York, told Dr. Harkin of a case which recovered with difficulty after taking ten grains of the salt. As a contrast, Dr. Harkin mentions the case of a young man who, having been supplied with a gargle containing an ounce of the salt, through mistake drank the whole at a draught, and did not experience the least inconvenience as a consequence. Whilst therefore Dr.

Harkin does not give any credence to the exaggerated statements which have lately appeared in the medical journals, he does not think that the prescription of this remedy should pass out of the control of the profession and become a merely popular medicine, but that it should be given with caution, though without reserve under medical supervision.

WHAT IS RESORCINE?—Resorcine, says the *Journal of Chemistry* (1881, p. 52), belongs to a class of bodies called *phenols*, to which carboic acid also belongs. In chemical composition they resemble alcohols. Pyrogallic acid is a triatomic phenol.

Resorcine was originally obtained by fusing certain resins, as gum ammoniacum or galbanum, with caustic potash, extracting it from the fused mass by acidifying with sulphuric acid and shaking with ether, and then purifying it by distillation.

Resorcine crystallizes in colorless plates or columns, and dissolves readily in water, alcohol, and ether. It melts at 104° Cent. (219° F.), and boils at 271° Cent. (520° F.), and can be obtained perfectly pure by distillation. It is claimed that it can be made in Switzerland for four dollars per kilometre (about one dollar and eighty cents per pound), but we find it quoted in German price-lists at from seven dollars and fifty cents to ten dollars per kilometre, or about twice the price of salicylic acid. To some extent the price will depend upon the demand.

Resorcine is not poisonous in moderate doses. From twenty-five to thirty grains is required to produce any marked effects. It has been found to reduce the temperature in febrile complaints, but its effect is of short duration, and unpleasant after-effects have been noticed. One of its isomers—hydrochinone—is preferred for use in fevers, the dose being smaller. The third isomer, pyrocatechine, has powerful toxic properties.

Andeer has recently investigated the properties of resorcine, and finds that it possesses the power of stopping decay. A one-per-cent. solution of chemically-pure resorcine will stop the development of fungi and mould. In every degree of concentration it coagulates albumen and precipitates it from solution, on which account it may be used as a caustic to remove unhealthy tissue. In crystals it cauterizes as powerfully as lunar caustic. In homœopathic doses resorcine will preserve ink and colors, which would otherwise mould quickly, and does not injure the color. To stop fermentation completely requires a rather strong solution of one and a half to two per cent.

Dr. Koller prophesies a great future for resorcine, which, he says, will be the disinfectant and antiseptic of the physician, the druggist, and the chemist. It must not be forgotten, however, that resorcine is too powerful a reagent to be taken internally in unlimited amount.

TREATMENT OF LABIAL OR MALIGNANT CARBUNCLE.—At the recent meeting of the American Medical Association (*New York Med. Record*, vol. i., 1881, p. 542), Dr. Charles A. Leale read a paper on this subject, in which, after giving an account of the etiology and pathology of facial carbuncle, he recommended the following treatment. Bearing in mind the *arteria septi nasi*, a free incision is made outward and downward along the course of the fibres of the orbicularis oris muscle, extending the cut each way until all the diseased tissue has been passed, taking care not to go through the mucous membrane lining the lip, to which the disease rarely extends; then, with a fine piece of ivory or wood covered with cotton, chemically pure nitric acid is thoroughly applied to the cut surface. This is to be pressed in with such force that every little pocket of pus is reached and the intervening membranes destroyed, which would otherwise be left to slough and to continue the septic or purulent infection. Morphia p. r. n. should be given, and whisky largely diluted with water. In some cases Dr. Leale has found it necessary to re-apply the acid on the second or third day. The subsequent treatment is that of an open wound, an ointment of balsam of Peru being applied upon lint.

Dr. Leale claims that by this treatment all the little canals making the cut surface appear like a sieve are reached and the entire poisonous mass rendered inert and kept within circumscribed boundaries, and the absorbed poisons, by sustaining the system, are eliminated. In the early part of the treatment a full dose of sulphate of magnesia, largely diluted with water, is given. Generally all danger is past by the third or fourth day. The scar left is usually small. Acute mania sometimes supervenes from erysipelas or cerebral meningitis. The latter is to be treated with hypodermic injections of morphia, the former by the usual lotions, etc. The cause of failure in carbuncle and malignant pustule treated by the ordinary method is that only a portion of the diseased mass is reached, the *materies morbi* imprisoned in the minute pustules being left.

CONSTITUTIONAL EFFECT OF CHRYSOPHANIC ACID.—Prof. Charteris (*Lancet*, vol. i., 1881, p. 651) relates the case of a boy nine years of age, admitted to his wards suffering with psoriasis. He was ordered to be rubbed with the chrysophanic acid ointment (one drachm to one ounce of vaseline), and four days later the nurse informed the doctor that the boy had been sick and vomited. Circumstances pointing to the absorption of the acid as a cause of this mishap, the strength of the ointment was reduced one-half, and the little patient recovered from his psoriasis without further untoward symptoms. But the idea was suggested to Prof. Charteris's mind that the acid might have acted constitutionally, and

in several cases of psoriasis coming under his care subsequently a portion of the body affected, as an arm or leg, was wrapped up and protected from the action of the ointment which was applied elsewhere. The effect was somewhat surprising, for although the disease did not disappear so rapidly upon the protected portion of the skin, yet it did disappear during the employment of chrysophanic acid inunctions upon an entirely different part of the body.

IODIDE OF ETHYL IN ASTHMA.—The *New York Medical Journal* for June, 1881, publishes three cases of asthma treated with inhalations of iodide of ethyl, with remarkable benefit. They occurred in Dr. R. M. Lawrence's service at the Boston Dispensary. Following the cases are some remarks by Dr. Lawrence, in which he says of the iodide of ethyl, "Its speedy absorption into the blood, its antispasmodic quality, and prompt reflex stimulation of the respiratory muscles, may reasonably account for its beneficial action in the asthmatic paroxysm, while its power of liquefying and detaching accumulations of mucus sufficiently explains its curative influence in chronic bronchitis. . . . Experience has confirmed my faith in its remedial worth in a large majority of cases of labored respiration (whether due to bronchial spasm or to increased mucous secretion), and also in certain obstinate cases of dyspnoea, not due to organic pulmonary or cardiac lesions, where other remedies may have proved inefficient. In a small minority of cases it has failed to afford relief." He does not recommend it as a substitute for internal medication, but rather as an adjunct thereto.

TREATMENT OF CARBUNCLE BY THE ETHER SPRAY.—Zimberlin (*N. Y. Med. Rec.*; from *Schmidt's Jahrb.*, No. 1, 1881) has obtained favorable results in two cases by this method. The first was a malignant pustule, which, on the fifth day, was as large as a fifty-cent piece, and surrounded by an intensely red areola. Ether spray from a Richardson's atomizer was directed upon it and its temperature reduced. On the following day the pustule was found covered with a dry scab and surrounded by a large inflammatory areola. Five days later the inflammation had subsided, the scab came away, leaving only a sensitive skin behind it. The same treatment was successful in a case of carbuncular oedema in an arm which it had already been decided to amputate.

FLUORIC ACID IN BRONCHOCLE OR GOITRE.—Dr. Woakes (*Lancet*, vol. i., 1881, p. 497) has used fluoric acid in twenty cases of goitre, with seventeen cures and three failures resultant. The acid was given in the dose of fifteen minims to one drachm thrice daily, largely (two hundred parts) diluted with water. Injections of iodine and the coincident administration of iron and tonics aid the effect of the fluoric acid, which in some cases produces its effect with surprising rapidity.

MISCELLANY.

A NEW DEPARTURE IN THE REGULATION OF PROSTITUTION.—As the question of the legal regulation of prostitution is now coming in different ways before the medical profession, the recent action of the Municipal Council of Paris in reference to it may be of interest.

In all countries where government regulation exists it has been found necessary to establish a special police for the enforcement of its regulations, and tribunals, consisting of magistrates, or officials specially designated, before whom women arrested under them are brought for the more speedy and private settlement of points growing out of the regulations, so as to avoid the slow proceedings and public scandal of such proceedings in ordinary court-rooms. This private and arbitrary mode of dealing with these women has always been one of the points most strongly objected to by the opponents of the system, and has been equally warmly upheld by its supporters, and has been adopted even in England.

At a meeting of the Municipal Council of Paris, held December 28, 1880, it was resolved, by a majority of 33 to 12, to abolish this police and their private tribunals.

The following are the resolutions, as given by the *Bulletin Continental* of January 15:

"The Council considering that the existing institution of the 'Police of Morals' violates individual liberty without accomplishing the results expected from it in its two objects,—the diminution of syphilis and the repression of offences against public order and morals,
—*Resolved*,

"*First*.—That the municipal administration is requested to prepare, as speedily as possible, a plan for the establishment of gratuitous medical and pharmaceutical service for the treatment of syphilitic disease.

"*Second*.—The municipal administration is requested to prepare a system of organization which will substitute the ordinary police for the present agents of the police of morals, in everything concerning the preserving of public order in reference to prostitutes.

"*Third*.—Violations of public order and morals shall no longer be referred to arbitrary, special administration, but to the regular course of justice.

"*Fourth*.—The result of this reorganization shall be the suppression of the police of morals, to take effect on January 1, 1882."

The same change has been made, it is said, at Brussels. The fact is of especial interest, because Ricord, in a recent editorial on the subject of regulating prostitution, declares that the Bureau des Mœurs is an essential part of it. If one goes, so must the other. This remains to be seen, however.

AN ÆSTHETIC HOSPITAL WARD.—One of the wards in the Louth County Infirmary at Dundalk has just been reopened, having been

refitted at considerable expense by Lord Clermont. The ward, which has been named after the noble lord, in recognition of his generosity on previous occasions to the institution, is thirty-seven feet long by eighteen. The ceiling is vaulted, having an opening in the centre to carry off the foul air. The walls are formed by a deep-brown skirting tile, surmounted by turquoise-blue hexagonal tiles and a moulded cutting-tile of brown and lemon color. The entire forms a dado five feet one inch in height, reaching to the window-sills. The plastering above is finished in Keen's Parian cement, of a delicate salmon color. An extremely-handsome stone chimney-piece, five feet eight inches in height, elaborately carved in the upper cross-piece, and having the words "I was sick and ye visited me" carved across the front, stands at the end of the ward. The fender is also Portland stone, the fireplace being tiled and containing a handsome dog-grate.

THE MANUFACTURE OF VINEGAR.—A German with the suggestive name of *Wurm* has established a factory at Breslau for the manufacture of vinegar from alcohol and water by the aid of *Mycoderma aceti*. The operation is performed in large wooden vats, provided with covers pierced with minute holes, and pipes for the renewal of the acetic alcohol and the withdrawal of the vinegar when it has reached the proper strength. The operation is begun by adding to the vat of water 2 per cent. of alcohol, 2 of ordinary vinegar, and 0.01 per cent. each of potassium, calcium, and magnesium phosphates, and 0.02 per cent. of ammonium phosphate. The temperature is kept at about 80° Fahr. The surface is then sown with a layer of *Mycoderma aceti*, and the lid fastened down. The acetication is said to proceed at more than double the usual rate. The phosphates form the natural food of the mycoderma, and keep them in good health and condition.—*Boston Journal of Chemistry*.

POLYPODIUM INCANUM.—We have received from Dr. C. H. Mastin, of Mobile, a specimen of the above plant, with the following statement:

"It has been brought to my notice by a very intelligent lady from the interior of this State, who informs me that it is largely used by the negroes and others in the country as an emmenagogue, and that, in her observation, it is vastly more reliable than anything she has known used.

"She tells me that she knows of one plantation upon which there are a very large number of negroes residing, and that she is positive there has not been a child born there for years past, and it is well known that the females are in the habit of anticipating every menstrual period by a cup of the decoction of this plant.

"I have under my care at this time a lady from the country who has been suffering from

uterine trouble and difficult menstruation, who tells me she is always quickly relieved by a teacup of the decoction of the plant which I send you."

AMERICAN MEDICAL COLLEGE ASSOCIATION.—The late meeting of this association at Richmond was a pronounced failure, and the indications are that it was the beginning of the end of the organization. Although there were present in the city a goodly number of representatives of the medical colleges of the country, it was only after several attempts that a quorum was drummed up. The spasm of virtue which resulted in the fixing of the three courses of lectures, a year ago, has relaxed, and there seems to be a disposition to prepare for a very general collapse next year, when the three-session plan is to be enforced. The withdrawal of leading Eastern schools, and the expressed determination of others (Jefferson, for instance) to withdraw when the time arrives when the three courses are to be made a condition of membership, has had a very disheartening effect on the small Western schools. Jefferson, in spite of the demi-gods in its faculty, is, like most of the other medical schools, run for lucre; and since it has transpired that in spite of its immense facilities for clinical instruction it does not make a utilization of them a condition of graduation, lest perchance such condition might keep away students, the stand taken by its representative, Dr. Gross, at the late meeting, was not a surprise. Self-interest controls them all, and that, too, in spite of claims of devotion to the "good of the profession," "a higher medical education," and all such cant.

What will the West do under the circumstances? Remain steadfast and thus sacrifice her schools, or return to the two-course plan?

The College Association, it is to be feared, is powerless for reform, and the profession cannot compel it. Then how is it to be effected? The only bodies having the means in their hands to compel it are the State legislatures, who can divorce the teaching from the examining and licensing body; but they will require much educating before they move in the matter.—*Michigan Medical News*.

THE APOTHECARY'S PRAYER.—One of the objects of interest at the recent meeting in Richmond, and which was a source of considerable amusement and banter, was a reprint of an old engraving representing a cadaverous pharmacist kneeling before a chair and offering up the following supplication:

"O mighty *Æsculapius*! hear a poor little man overwhelmed with misfortunes; grant, I beseech thee, to send a few small fevers and some obstinate *catarrhs* amongst us, or thy humble supplicant must shut up shop. And if it should please thee to throw in a few *cramps* and *agues* it would greatly help thy miserable servant; for, on the word of an

Apothecary, I have scarcely heard the music of a mortar this two months.

"Take notice also, I beseech thee, of the mournful condition of my neighbor CRAPE, the Undertaker, who suffers considerably by my want of practice, and loses many a job of my cutting out: enable him to bear his misfortunes with philosophy, and to look forward with new hope for the tolling of the bell.

"Physic those, I beseech thee, that will not encourage our profession, and blister their evil intentions, viz., such as their cursed newly-invented water-proof; and may all the coats be eaten by the rats that are so made. But pour down the *Balm of Gilead* on the Overseers of the village, and all the friends of *Galen*.

"May it please thee to look over my book of bad debts with an eye of compassion, and increase my neighbors' infirmities; give additional twinges to the Rector's *gout* and our worthy Curate's *rheumatism*; but above all I beseech thee to take under thy especial care the Lady of Squire HANDY, for should the child prove an heir, and thy humble servant so fortunate as to bring the young gentleman handsomely into the world, it may be the means of raising me to the highest pinnacle of fortune."

PROFESSOR PIROGOFF.—The fiftieth anniversary of the professorship of this eminent surgeon was celebrated on June 5. From the Russian journals we learn that he commenced his studies in the University of Moscow in 1824, and left in 1828, being then only seventeen years of age. After this he attended lectures in Dorpat and Heidelberg, and when only twenty years old was appointed to the chair of surgery in Dorpat, where he taught anatomy from 1836 to 1840. In the latter year he was invited to the professorship of surgery in St. Petersburg. In 1848 he served with the army in the Caucasus, and in 1853 in the Crimea. At the recent meeting of the German Surgical Congress it was resolved to send him an address on the occasion of the anniversary.

THE cable announces the death of Dr. Josef Skoda. Born in Bohemia in 1805, he graduated at the Vienna medical schools in 1831, in 1834 became second physician to the general hospital at Vienna, and became successively physician for the division of lung diseases, chief physician of the hospital, Professor of Clinics, and a member of the Vienna Academy of Sciences. Professor Skoda was one of the first to popularize the use of the stethoscope of Laennec, was a great authority on pathological anatomy and on the new methods of auscultation and percussion, and was considered the head of the new German school of diagnostics.

WHOLESALE DISTRIBUTION OF COFFINS.—In the report of the Municipal Special Committee of Hygiene of Rome, says the *Lancet*, we are told, with some unction, that, although

there were only 722 deaths in the month of February, no less than 525 coffins have been distributed gratuitously to the poor.

NOTES AND QUERIES.

OBITUARY.

DR. H. LEMOX HODGE, Demonstrator of Anatomy in the Medical Department of the University of Pennsylvania, died in this city, on June 9, in the forty-fifth year of his age. He was a son of the late Hugh L. Hodge, the distinguished obstetrician. Graduating in medicine from the University of Pennsylvania in 1858, he served in the army during the late war, taking part in various campaigns, and also serving in the Satterlee Hospital in West Philadelphia. In 1870 Dr. Hodge received the appointment of Demonstrator of Anatomy in the University, an office which he held until his death. Dr. Hodge was somewhat reserved in manner, and was in consequence less widely known perhaps than his abilities would have justified; but within the circle of his acquaintance he was much beloved, and his lofty personal character, public-spirited philanthropy, and devotion to the best interests of the medical school gained him the unfeigned esteem of the profession. He was the author of a number of papers on surgical subjects, an active member of the Pathological Society (of which he was at one time president), and a zealous promoter of the cause of charity organization.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM MAY 29 TO JUNE 11, 1881.

BAILY, E. I., LIEUTENANT-COLONEL AND SURGEON.—So much of Par. 1, S. O. 112, c. s., from A. G. O., as directs him to report in person to the Commanding General, Division of the Pacific, for duty as Medical Director of the Department of California, is revoked. S. O. 121, A. G. O., May 27, 1881.

Having reported at Division Headquarters, in compliance with S. O. 112, Par. 1, c. s., A. G. O., is assigned to duty as Attending Surgeon in San Francisco, relieving Surgeon C. C. Keeney. G. O. 10, Division of the Pacific and Department of California, May 31, 1881.

COVENS, E., CAPTAIN AND ASSISTANT-SURGEON.—Assigned to temporary duty as Post-Surgeon at Fort Verde, A.T. S. O. 56, Department of Arizona, May 20, 1881.

CORSON, J. K., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for one month, with permission to apply for an extension of two months. S. O. 61, Department of Arizona, May 31, 1881.

HEIZMANN, C. L., CAPTAIN AND ASSISTANT-SURGEON.—The telegraphic instructions of 22d instant to Commanding Officer, Fort Townsend, W.T., directing Assistant-Surgeon Heizmann to report at these Headquarters, confirmed. S. O. 71, Department of the Columbia, May 23, 1881.

AINSWORTH, F. C., CAPTAIN AND ASSISTANT-SURGEON.—Relieved from temporary duty at Post of San Antonio, Texas, and assigned to duty at Fort Clark, Texas. S. O. 76, Department of Texas, May 31, 1881.

SHUFELDT, R. W., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Assigned to temporary duty in the Surgeon-General's office. S. O. 129, A. G. O., June 7, 1881.

PERLEY, H. O., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from duty in Department of Dakota, and to comply with S. O. 104, c. s., A. G. O. S. O. 97, Department of Dakota, June 6, 1881.

POWELL, J. L., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from duty with Co. "A" Twenty-Second Infantry on arrival at Fort Concho, then to proceed to Fort Stockton, Texas, and report to Post-Commander for duty as Post-Surgeon. S. O. 76, c. s., Department of Texas.

BENHAM, R. B., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from duty at Fort Abraham Lincoln, D.T., and assigned to duty at Fort Assiniboine, M.T. S. O. 97, Department of Dakota, June 6, 1881.